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ABSTRACT

Ways to initiate or improve allied health education activities are discussed to assist faculty and administrators in colleges or universities that enroll significant numbers of minority students. The information was developed as part of the American Association of State Colleges and Universities' (AASCU) Minority Allied Health Project, which provided technical assistance to minority institutions. Criteria to evaluate an institution's potential for developing allied health programs are presented, along with a list of major background materials. In addition, information is provided on how to estimate program costs and to conduct feasibility studies and surveys of personnel and clinical resources. Guidelines for developing new and cooperative allied health programs are included, along with information on assessing and improving current programs. Finally, specific strategies for promoting allied health career awareness and student recruitment and retention are outlined. Appended materials include sample feasibility studies, consultant reports, and affiliation agreements, as well as a list of recommended consultants in the allied health education field and the names of contacts at institutions currently developing allied health activities under the AASCU project. (SW)

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ALLIED HEALTH EDUCATION DEVELOPMENT

A Comprehensive Model for Colleges and Universities
with Special Emphasis on Minority Recruitment

PRODUCED BY

The Minority Allied Health Project
Marcia V. Bcyles, Ph.D.
Director

American Association of State Colleges
and Universities
Washington, DC

Pursuant to Contract #HRA 232-79-0030

FOR

U.S. Department of Health and Human Services
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Health Resources Administration
Office of Health Resources Opportunities

February 1983

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FOREWORD

We at the Division of Disadvantaged Assistance (formerly, OHRO) are very proud of this publication. It represents over three years of effort in a highly successful contract project conducted by the American Association of State Colleges and Universities under funding granted by this office. Through the combined efforts of this office and the Association, over 20 minority colleges and universities have developed a large number of new allied health activities.

There were many lessons learned during the conduct of the project—lessons that should be directly and immediately helpful to the many qualified and capable colleges and universities with large or predominant minority student populations that are considering or already developing allied health programs on their campuses. It has been the aim of my office, then, to provide a model for these institutions that were *not* part of the project, so that they, too, will derive benefit from the contract and be provided assistance in their future endeavors in allied health education.

Best wishes for success!

Clay Simpson, Ph.D.
Director
Division of Disadvantaged Assistance
Health Resources and Services Administration
Hyattsville, Maryland

PREFACE

This publication is especially designed to be used by faculty and administrators in colleges and universities with significant or predominant minority student populations—Black, Hispanic, or Native American—who have an interest in developing or improving allied health education activities at their institutions. The publication should also be useful for any collegiate institution, whether two-year or four-year, public or private, that already has in place or is planning for allied health education programs, particularly those that are actively recruiting minority students to the programs. This publication provides ways to evaluate an institution's potential for allied health program development and guidelines for the actual development of new and cooperative programs in allied health: it also outlines benchmarks for assessments of allied health programs already in place and recommends steps for their improvement.

The impetus for this publication was a recognition by DHHS' Office of Health Resources Opportunities (OHRO) that strong interest in allied health activities existed on the part of minority colleges and universities. This recognition led to the award by OHRO in 1979 of a three-year contract to the American Association of State Colleges and Universities (AASCU) to assist 23 senior-level minority institutions to develop or improve allied health programs or to develop new cooperative arrangements for allied health activities on their campuses. The process was a rigorous and lengthy one, involving campus personnel, project staff, consultants, accrediting agency personnel, as well as others from external agencies and organizations. Although designed to benefit the participating institutions, the project also educated project staff members to the complexities of successful allied health program development in minority colleges and universities. (Staff experience in allied health education, though extensive, had largely been in majority settings). This publication, then, is the result of lessons learned during the conduct of the contract project.

It is hoped that all minority institutions of higher education with an interest in allied health education will find this publication helpful, especially the more than 50 colleges and universities that applied but could not be accepted for participation in the project. (Many of them were clearly willing and able to undertake allied health activities).

Special thanks should go to the presidents of the participating institutions, who were most cooperative from the beginning, and to the campus liaisons from the participating colleges for their fine efforts. In addition, our deep appreciation is expressed here to the myriad people who aided us in invaluable ways during the conduct of the project—hospital administrators, professional association personnel, consultants, health science center deans, and state and local education and health planning agency personnel, as well as the project Steering Committee, which consistently provided us with good advice.

Finally, on behalf of the project staff, I would like to thank AASCU's Executive Vice-President, Dr. Harold Delaney, for his continued interest and efforts during the conduct of the project, and Mr. Horace Carpenter, Project Officer, OHRO, for his impeccable efforts on behalf of the project. Our appreciation, too, is extended to Dr. Clay Simpson, Director, OHRO, under whose leadership the contract was granted and conducted.

Marcia V. Boyles, Ph.D.
Director, Minority Health Project

CONTRIBUTORS

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SECTION I. PROJECT BACKGROUND AND INTRODUCTION

A. Background to the Project

In the early 1970's, a number of colleges and universities began to examine the possibility of developing allied health programs on their campuses. The programs usually had high visibility and were quite attractive to students; thus they tended to be viewed as one of the areas that might partially replace the demand for teacher education. Once institutions decided to explore allied health education, they quickly discovered that the magnitude of time and effort required for planning and implementing new programs was far greater than they had anticipated. It was in recognition of the appeal of allied health programs and the complexity of their development on campuses that the American Association of State Colleges and Universities (AASCU) formed an Office of Health Affairs in 1972.

In 1975 several AASCU members that are traditionally Black institutions asked the staff for site visit consultations. The visits were made, as was a presentation to a consortium of Black institutions, public and private, regarding allied health program development. From those initial contacts arose a growing awareness and an early, if again somewhat naive, understanding that minority colleges and universities faced some rather special and severe difficulties in developing allied health programs. It was obvious from the outset that these institutions were not getting the advice and assistance from area health professionals and clinical facilities, from health or educational planning boards, or from professional associations—as were their majority counterparts. Like majority institutions, they rarely had faculty or administrators on their campuses uniquely prepared to determine the feasibility of allied health programs, then to plan and implement them. In minority institutions, however, there was usually the added difficulty of a lack of release-time funds available to provide campus personnel with the time required to obtain the necessary skills and knowledge. The lack of campus personnel time, combined with limited support (if not actual opposition) from outside groups and individuals, was usually sufficient to preclude minority schools from initiating allied health programs.

The resultant dearth of allied health programs offered by minority institutions was clearly shown in two unpublished studies by the AASCU staff, both based on 1975 inventory data collected by the American Society of Allied Health Professions (ASAHP). The first compilation by AASCU staff (1976) revealed that in 13 southern states, among majority AASCU-member institutions, the average number of allied health programs offered by each college or

university was 2.8; among minority AASCU-members in the same states, the average number of such programs was 1.0 per institution. More recently (1979) compiled data revealed that in the 120 senior-level colleges and universities (private and public) in the U.S. having a minority student population of 45 percent or greater, there was a total of only 142 allied health programs. The most prevalent (36) allied health programs among these 120 institutions were the so-called 3:1 medical technology programs in which hospitals assume primary responsibility for the clinical training of students during their senior year. Among all of the 120 schools there were only two programs in each of the areas of physical therapy, occupational therapy, medical records administration, and dental hygiene.

Many minority colleges and universities that initiated allied health programs faced severe difficulties, including (1) recruitment of qualified faculty; (2) recruitment of qualified students and low rate of student passage of professional certification exams; (3) lack of ability to obtain appropriate and adequate clinical training sites for students; (4) lack of administrative support for the programs; and finally, largely as a result of the first four, (5) difficulty in obtaining and keeping program accreditation. Further, as a consequence of these difficulties in many of the minority colleges and universities examined in the 1979 study, the allied health programs that were offered were often somewhat out of the mainstream of allied health education. (Programs considered to be out of the mainstream were usually less rigorous, less expensive, offered more limited professional growth potential for graduates, and often were lacking in established program accreditation standards. Specific examples of such programs include food and nutrition, corrective therapy, and 3:1 medical technology programs. Respective counterpart programs in the mainstream are dietetics, physical therapy, and integrated medical technology.)

In order to better understand the context in which the efforts of minority colleges and universities occurred in allied health program development, it is important also to know the status of minority students elsewhere and of practitioners in the fields. Both the available data (Flack, 1980) and staff observation indicate that minority students were and continue to be underrepresented in upper-level allied health programs in majority colleges and universities. There appears to be a number of reasons for this underrepresentation. At least one study, a three-part series of publications sponsored by DHEW's Division of Associated Health Professions, 1975, identified barriers to Black, Hispanic, and Native American students in the allied health fields as lack of information, counseling, recruitment, motivation, and finances. The study concluded that

... most minority students do not include the allied health fields in their career selection process because they have no knowledge or inadequate knowledge of the career opportunities available. The few minority students that do enter postsecondary programs find the academic work difficult, sense a feeling of social isolation and seem unable to find or get the ancillary supportive services they need to successfully deal with their environment.

Generally, it appears that whether in practice or in training, the more sophisticated the field, the fewer the minorities. Minorities, then, tend to be clustered in the assistant and

technician levels (e.g., medical assistant, laboratory technician), and scarce among technologists and other baccalaureate-level allied health professionals (e.g., physical therapists, occupational therapists, medical record administrators).

That the underrepresentation of minorities in allied health has a distinct negative impact on the health care system can be readily envisioned. Among Hispanics and Native American populations (and to a lesser extent, among Blacks), language and cultural needs of health care consumers tend to be not at all or inadequately addressed by non-minority allied health practitioners. Constraints, then, on non-minority practitioners' functionality and the quality of health care delivered are obvious in such fields as speech pathology, dietetics, dental hygiene, and occupational therapy. Further, in many medically underserved regions, especially in large urban areas and in rural sections of the South and Southwest, allied health professionals are often in short supply. These regions have traditionally high minority populations; thus it can be inferred that since minorities have a high rate of return to work in the areas of their origins, allied health practitioners would increase in number in those medically underserved areas were more minorities being trained.

Because relatively few minority students are enrolled in baccalaureate-level allied health programs in majority institutions, *minority colleges and universities play a disproportionately large role in the training of students in these fields*. Flack (1980), for example, reported that nearly 40 percent of minorities being trained in the various allied health professions are receiving that training at a minority institution. This situation is perhaps unique in modern education for minorities, although past parallels abound (e.g., Blacks establishing separate medical and other professional schools largely because they were unable to gain admittance to those programs in majority institutions). Again, the significance of this situation is particularly acute in view of the paucity of allied health programs and especially mainline programs in minority schools, as well as the special difficulties those institutions face in initiating and conducting the programs.

It was recognition, then, of the underrepresentation of minorities in allied health programs in majority institutions, of the uniquely important role being played by minority institutions in this training, and of the special obstacles that they faced in fulfilling that role, that provided AASCU with the impetus to seek to give assistance through this project. While AASCU reached this decision essentially independently, it is significant to note that virtually identical conclusions had been drawn by two other groups, viz., the National Urban League, which had conducted a study of historically Black institutions (HBI's) vis-a-vis allied health in 1972, and the Institute for Services to Education (ISE), which evaluated health science efforts at many of the same institutions in 1977. The National Urban League recommended that professional associations cooperate actively with Black institutions to develop strong allied health programs; ISE recommended that "a major federal initiative be launched to assist HBI's to upgrade existing health science programs as well as to establish new programs."

Initial discussions with representatives of DHHS' Health Resources Administration took place in late 1976, and AASCU was awarded a three-year contract by the Office of Health Resources Opportunities (OHRO), Health Resources Administration (HRA), DHHS in March 1979.

B. The Contract Project

The contract (HRA #232-79-0030) was designed to provide technical assistance to selected minority colleges and universities in the development of their allied health activities: i.e., the development of new programs, the improvement of existing programs, and/or the development of new cooperative arrangements with other institutions. A brief description of the methodology and of the results of this project are pertinent here for several reasons. First, the series of steps taken on each campus to reach the objectives are essentially the same steps that will be discussed in more detail as appropriate for the users of this publication who are interested in initiating or improving allied health activities on their campuses. Second, the methodology should provide a brief overview of the *process* of the development of allied health activities, putting the steps into a conceptual framework.

The project was conducted in three phases; each phase required approximately one year for completion. The major activities of each phase were as follows:

Phase I (1979-1980)

- Select project staff (listed in Appendix A).
- Appoint project Steering Committee (listed in Appendix B).
- Prepare a "state-of-the-art" report outlining major past efforts toward increasing minorities in allied health; report to be used by project staff and steering committee.
- Determine which senior-level colleges and universities were eligible to participate in the project based on a minimum total student enrollment of 500 or greater, and a minority (Black, Hispanic, Native American) student enrollment of 45 percent or greater. Notify institutions of their eligibility.
- Request written information from interested eligible institutions on the following:
 - past and present efforts in health science programs;
 - science offerings;
 - institutional grants and contracts;
 - institutional support services;
 - commitment to minority education;
 - administrative commitment to allied health education;
 - present relationships with health facilities and agencies;
 - present relationships with other educational institutions and agencies vis-a-vis allied health;
 - community setting;
 - name and qualifications of a potential campus liaison to the project who will head the institution's efforts in allied health and work with the project staff during the project.

- Establish criteria for the selection of institutions to the project. Criteria, determined by staff and steering committee, included the following (in order of priority):
 - administrative commitment to allied health;
 - student remediation potential;
 - minority population mix of student body;
 - institutional financial resources;
 - institutional resources (facilities/space/equipment);
 - science curricula;
 - institutional ability to attract funds;
 - institutional potential for allied health program accreditation;
 - health manpower needs of the area;
 - previous innovative developmental activities of the institution;
 - existing health science programs at the institution;
 - campus liaison qualifications;
 - student support services of the institution;
 - community characteristics (demographic);
 - recruitment/motivation programs of the institution;
 - philosophy/mission of the institution;
 - institutional participation in consortia;
 - state board attitudes/policies re: allied health development at the institution;
 - clinical facilities in institutional proximity;
 - student academic profiles;
 - institutional relationships with outside agencies.
- On the basis of written information submitted by institutions and information and assessments provided by the project staff, the steering committee makes an initial selection of 36 institutions to be further considered for project participation.*
- Obtain further information about the 36 "finalists" through two–three day staff site-visits focusing on the following:
 - campus liaison, administrative, and science faculty interest in, and attitudes about, allied health activities;
 - assessment of science facilities and equipment, and space resources available for allied health activities;

* Based on the established size and minority student enrollment criteria, 120 senior-level colleges and universities were determined to be eligible for participation in the project. The 120 institutions were notified of their eligibility and asked to submit written information, as indicated; 74 institutions responded with formal applications for participation and submitted the requested information. The project staff prepared written assessments of each institution's materials and gathered basic data on the clinical resources located within a 50-mile or so radius of each applicant institution. Staff also solicited letters for the efforts of institutional applicants from state or regional health planning agencies, state hospital associations, and state boards or commissions of higher education. These solicitations were accompanied by a full explanation of the nature of the project.

- existing allied health programs at nearby institutions and potential for cooperation;
 - particular or acute manpower needs of the area;
 - attitudes of state boards/commissions of higher education regarding the allied health potential of the institution;
 - any other strong area or institutional strengths or weaknesses that would have bearing on allied health program development, including attitudes, facilities, and faculty.
- Based on written staff assessments of allied health program development potentials for each of the 36 finalists, and using the established selection criteria, the steering committee chose a total of 23 institutions to participate in the project. (A list of the participating institutions and their campus liaisons is attached as Appendix C.)*
-

Phase II (1980-1981)

- Develop written agreements with each participating institution outlining the precise role of AASCU and ensuring the confidentiality of information during the conduct of the project, and also outlining the precise role of the institution in providing information and release-time to its campus liaison.
 - Provide training to the campus liaison in the areas of:
 - role of the campus liaison;
 - allied health education requirements;
 - external and political influences in allied health education;
 - the health care delivery system;
 - community and clinical relationships;
 - cooperative agreements and arrangements.
 - Together with the campus liaison, gather information for each institution regarding:
 - area (local, regional, state) allied health manpower needs;
 - potential student interest;
 - faculty resources for allied health activities;
 - budget and internal funding sources;
 - institutional facilities for allied health activities;
 - external agencies crucial to allied health efforts (educational and health planning boards, professional associations, and so forth);
-

- * Of the 23 institutions chosen to participate in the project, five were considered to be "demonstration" schools, i.e., those already having strong allied health programs which therefore needed fewer services from the project and which could themselves provide some technical assistance to the other participating institutions.

Of the 23 participating colleges and universities, 18 are traditionally and/or predominantly Black, four Hispanic, and one (Northern Arizona University) has a significant Native American student population.

- formation of an advisory committee;
 - clinical facility strengths and personnel attitudes;
 - potential for cooperative relations with other educational institutions (community colleges and senior institutions);
 - any other information having a bearing on allied health program development at the institution.
- Using information gathered by the campus liaison and by project staff, prepare a formal feasibility study for each institution describing specifically which allied health programs it might offer, based on preclinical and clinical needs of the programs, institutional and area strengths and weaknesses, and the availability of other (political, etc.) external support. Fully discuss the report with the institutional liaison, the president, and other members of the central administration, as requested by the institution. The institution determines which potentially feasible programs it would like to continue exploring.
 - Prepare and disseminate a bi-monthly newsletter, *UPDATE*, which includes information of interest to minority colleges and universities developing allied health activities.
-

Phase III (1981-1982)

- Continue *UPDATE* publication.
- Continue campus liaison training in following areas:
 - grant proposal preparation;
 - programmatic budget projection and preparation;
 - student career awareness/recruitment/retention strategies;
 - administrative arrangement and considerations for allied health programs;
 - faculty and program director recruitment and retention;
 - contractual arrangements and agreements with clinical facilities;
 - cooperative arrangements with other educational institutions.
- Identify and secure the services of outstanding consultants in the allied health fields selected by the institutions for further consideration. For each institution, a consultant in each selected field will make a two-three day campus site-visit and prepare a formal report outlining the following:
 - an assessment of the campus curricular offerings and facilities for the preclinical portion of the program;
 - an assessment of area clinical facilities and personnel for student clinical training in the program;
 - a timetable projected for implementation of the program, and a "needs" statement outlining the specific facility, faculty, course, and budget requirements for the program.
- Identify and contact foundations that might have an interest in funding allied health activities at the participating institutions.

- Work with participating institutions and other educational institutions in the development of consortia and other cooperative arrangements for allied health education.
 - Identify potential private funding sources for a "package" of miniproposals, and submit the proposals to foundations and agencies. (Twenty-one of the 23 participating colleges and universities have elected to seek external funding for their new allied health activities as part of a "package.")
 - Prepare a comprehensive model for the development of allied health activities in minority institutions (i.e., this publication).
 - Prepare a faculty recruitment booklet describing the participating institutions and the allied health faculty and program director needs of each; distribute the booklet to potential applicants for the positions.
-

Project Results

As a result of this project, 21 of the 23 participating colleges and universities plan new activities in allied health. (Two institutions, Northern Arizona University and the University of Arkansas at Pine Bluff, withdrew from the project; both universities underwent central administration changes during the course of the project.) The new allied health activities planned by the participating institutions (see Appendix D) are summarized below:

- 22 new allied health programs;
 - 9 improved allied health programs;
 - 8 cooperative or linkage arrangements (involving 21 programs);
 - 8 career awareness/student recruitment/retention programs and/or new preclinical courses and/or new health science units or administrative arrangements;
 - 1 new consortium (with 5 institutional participants).
-

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SECTION II. FEASIBILITY OF ALLIED HEALTH ACTIVITIES

A. Introduction

The first step in determining what allied health education activities an institution might best undertake is to conduct a thorough feasibility study. This step is often a difficult one for colleges and universities because it requires a time-consuming examination of internal strengths and weaknesses as well as of a number of external factors. The final result of a feasibility study should be a recommendation for the initiation of specific allied health programs, the improvement of existing programs, cooperation with other educational institutions in allied health, some combination of these options, or a recommendation to undertake no allied health activities at all. The degree of rigor, objectivity, and political sensitivity with which the feasibility study is conducted will have a direct relationship to the ultimate ability of the institution to develop successful allied health programs. Immediate considerations of a feasibility study are listed below.

Who Should Conduct the Feasibility Study?

One individual on the campus should be appointed to the task. An advisory group can often be helpful and consultants are usually crucial to the final phase of the study. The individual appointed to conduct the study should be a full-time employee of the college or university, either a faculty member or an administrator. This individual should be appointed with the expectation that he or she will continue being administratively involved in all future allied health efforts of the institution. Ideally the individual appointed to conduct the feasibility study would have all or most of the following qualifications:

- Previous direct involvement with allied health science programs at an institution of higher education;
- Good relations or have the potential for good relations with community personnel;*
- Good organizational ability as well as competency in grant and budget preparation;
- Solid understanding of the curricular offerings of the institution, particularly in the sciences;*
- Basic knowledge of the health care delivery system;

* Most important characteristics.

- Understanding of curriculum development;
- Ability to work one-third to one-half time for at least one or two semesters of the feasibility study, and potentially full-time in allied health program development thereafter;*
- Political sensitivity and sophistication, with the potential to interact well with local, state, and national agencies;*
- Demonstrated initiative and drive to complete tasks with little or no supervision.*

While few campuses will have available one individual possessing all of these qualifications, those that are asterisked should be weighed most heavily in the selection.

How Long Should the Process Last?

Assuming that the campus-based individual conducting the feasibility study is wholly or relatively inexperienced in allied health education, the process will generally require approximately one year on a half-time basis. A fully experienced person will probably require somewhat less time to complete the process. Whether the individual conducting the study is experienced or not, it is absolutely essential that he or she be provided with release-time.

What Background Materials Would be Helpful?

Four publications and two studies are important to the conducting of the feasibility study, and should, if possible, be obtained before it is begun.

<i>Publication or Study</i>	<i>Source</i>
<i>Essentials of Accredited Programs in Dental Auxiliaries</i>	Office of Education American Dental Association 211 E. Chicago Avenue Chicago, IL 60611
<i>Allied Health Education Directory</i> (latest edition; approx. \$14) (lists accreditation standards and accredited programs for the 25 allied health programs in which the AMA participates in accreditation. Also lists names and addresses of sources of information for each field.)	American Medical Association Order Department OP-049, Box 821 Monroe, WI 53566
<i>National and State Profiles of Collegiate Allied Health Education</i> 1979-1980 (\$17.50)	American Society of Allied Health Professions One Dupont Circle/Suite 300 Washington, DC 20036

* Most important characteristics.

<i>Publication or Study</i>	<i>Source</i>
<i>The Health Professions</i> 1982, by Boyles, Morgan, McCaulley (\$14.95) (Describes the work settings, and basic educational requirements for all health professionals; also includes chapters on the health care system, and names and addresses of sources of information.)	W. B. Saunders Publishing Co. West Washington Square Philadelphia, PA 19105
State plan for health manpower (when it exists)	State Board or Commission for Higher Education
A list of all health care delivery facilities in your region, including the type (e.g., nursing, home, general hospital, psychiatric hospital, etc.), number of beds, and administrators' names.	State or Regional Health Systems Agency

What Allied Health Programs Should be Considered?

This publication, like the AASCU project, is aimed at senior-level colleges and universities; thus, the allied health programs given primary emphasis are those on the baccalaureate-level, including:

- Allied health education
- Biomedical communications*
- Cytotechnology*
- Dental hygiene*
- Dietetics
- Health administration/management**
- Medical records administration
- Medical technology
- Music/art/dance therapy
- Nuclear medical technology*
- Occupational therapy
- Ophthalmic technician*

* Usually but not always offered on the baccalaureate-level.

** Programs traditionally offered on the masters-level, but more recently also on the baccalaureate-level.

- Physical therapy†
- Public health**
- Radiation therapy technologist*
- Respiratory therapy*
- Speech pathology/audiology††

Numerous other allied health programs are offered on associate degree or certificate levels. Examples of the former include medical laboratory technician and medical records technician; examples of the latter are EEG technician and emergency medical technician (EMT) programs. It should also be noted that programs in nursing, physician assistance, and graduate-level public health and health administration are not generally considered as allied health.

After the suggested publications and studies have been obtained and an individual appointed to conduct the feasibility study, the next steps will involve gathering information about the institution, allied health manpower needs, allied health programs at other educational institutions in the region and state, area clinical facilities, and other external influences.

B. Information Gathering

Allied Health Manpower and Clinical Resources

Information regarding allied health manpower needs and area clinical resources pertinent to allied health program activities can be gathered concurrently, since the sources of information are virtually the same. In seeking this information, a specific protocol needs to be adopted. First, reliable permanent records of all meetings and their results should be kept. Second, information needed from local and state personnel should be gathered through personal visits (i.e., scheduled appointments) by the individual conducting the feasibility study. Since the sources of information are individuals whose support will be crucial throughout all phases of developing and implementing allied health programs, the prearrangements for the meetings will be nearly as important as the meetings themselves. (It is important as well to remember that while you are meeting to solicit information, you are also tacitly soliciting support for future efforts.)

* Usually but not always offered on the baccalaureate-level.

** Programs traditionally offered on the master's-level, but more recently also on the baccalaureate-level.

† The American Physical Therapy Association has mandated that all entry-level programs be offered on the master's-level by 1990.

†† The practice of speech pathology/audiology requires a master's degree in many states.

Unless the individuals from whom information is sought know the person conducting the feasibility study, appointments with them should be made through the office of the college or university president, giving official sanction to the effort. It is also helpful if contacts within the health care community—influential physicians, members of the boards of hospitals, and so forth—are informed of the feasibility study. These contacts should let others within the health care community know that the study and their cooperation has visibility. This tactic tends to increase, albeit not ensure, greater receptivity on the part of those from whom information is sought.

(A project staff member made the initial visits with campus liaisons to local and state offices and individuals from whom information was sought, thus viewing their reactions first-hand. The sources were usually non-minorities, and their reactions varied from outright hostility to expressed eagerness to cooperate. Two hospital administrators, for example, stated that they would "never allow their hospital to be used for training students from X minority college." A hospital administrator in the South told us that, regarding the use of his facility for training minority students, it was "not the way it was done here." Fortunately, genuine enthusiasm was more often expressed by facilities' administrators, and offers of cooperation including training space, staff time, and letters of endorsement were sometimes given.)

The attitudes of the individuals visited, while sometimes reflecting their own personal biases, also reflect the town and gown relations and, perhaps more importantly, reflect the individuals' stakes in the benefits of the initiation of allied health activities. For example, one hospital administrator's institutional accreditation was threatened by lack of available nursing and allied health personnel, while another hospital administrator's facility was used for allied health training by several collegiate institutions and thus had no allied health personnel shortages.

Finally, if the individual conducting the feasibility study is not well-acquainted with the health care delivery system, the process of gathering information should provide a unique opportunity for him or her to become so. Visits to agencies (e.g., health systems agencies, health departments) should provide the opportunity to request descriptions of the specific services provided by the agency. Visits to each clinical facility should include a request for a tour. Knowledge of the health care delivery system is helpful in understanding the terminology used while gathering information, and in interpreting what is seen and heard during the visits.

Allied Health Manpower Needs

Colleges and universities, along with health planners and others, have had consistent difficulty in obtaining reliable allied health manpower needs data or projections; indeed, differences exist in deciding how to determine such needs (e.g., on the basis of an area's clinical facilities, population, or budgeted positions unfilled, etc.). The available data tend to be most reliable when confined to a particular field and to a limited geographic area, and then only if the data are recent. Despite these caveats, effective efforts to gain general information, if not hard data, regarding the manpower needs of specific allied health fields can and must be made on local, state, and national levels. For each field and for each geographic

level there is no one source of information; rather, as many sources as possible should be tapped, cross-checking the results against each other.

Clinical Facilities

Clinical facilities are classified according to the types of care that they provide to health care consumers and by their ownership. Primary care is concerned with early detection and treatment of health problems; secondary care is the general services provided by hospitals; tertiary care is specialized treatment provided by large teaching hospitals or speciality facilities. Restorative or rehabilitative care, and continuing or long-term care are other categories. Examples of primary care facilities are out-patient clinics or neighborhood health centers. Secondary care is provided by general hospitals. Tertiary care facilities include psychiatric hospitals and university health science centers. An example of a rehabilitation facility is a Veterans Administration (VA) hospital; of a long-term care facility, a nursing home. Facility ownership can be proprietary (for profit), voluntary or nonprofit, or public or governmental.

The size and type of a clinical facility will largely dictate its services. Thus, a non-speciality (general) hospital of 400 beds or more will usually provide primary, secondary, and tertiary care, and occasionally rehabilitative services and beds. Such a facility will usually have the full range of service departments that both employ and potentially train allied health students, (e.g., medical laboratory, physical therapy, radiology, dietetics, respiratory therapy, and medical records). A hospital of 400 beds or more, and usually in conjunction with an educational institution, often has physician internship and residency programs and/or allied health training programs, and thus is considered to be a "teaching hospital."

Small general hospitals of 100 beds or fewer, while often having many of the same service departments as a large hospital, generally cannot be considered to be sufficiently staffed or equipped to be appropriate for student training. Hospitals in the 100+ to 400 bed range will vary in this capability.

While students in many of the allied health fields (e.g., medical technology, cytotechnology) usually receive their clinical training at only one facility, students in other fields such as physical therapy and occupational therapy usually receive their training at a number of different types of facilities, including extended care facilities, mental institutions, VA hospitals, and general hospitals.

Hospitals and other clinical facilities that are already training allied health students in their own programs and/or those of other colleges and universities may not be able to accommodate additional students. Program accreditation standards usually dictate the number of students that any given clinical department can train, depending mainly on the number of certified or otherwise qualified personnel employed by the department and the number and/or types of services provided.

Sources of Information

Local and Regional: Local and regional information sources can be broken down into the following categories:

- **Health Systems Agencies (HSA's)** are health planning boards mandated by federal law. Each HSA gathers data and makes decisions regarding the health care delivery system (facilities, personnel, and services) of a specific geographic area, which may be a state or portion of a state. The address and director's name of the HSA serving your area can be obtained from the local health department or hospital administrator's office.

The emphases and capabilities of HSA's vary widely, but if the director presently does not have regional allied health manpower data, he or she will know whether any other agency has collected such information. If allied health manpower data for the region do not exist, the HSA may be willing to collect it, or to assist the college or university in doing so.

As indicated, the HSA should, early on, be asked to provide a list of all clinical facilities in the region, including number of beds, types of services provided, and administrators' names.

- **Local Health Departments** can provide valuable general information and observations on the overall health care deficiencies and strengths of a geographic area, particularly with regard to underserved populations.
- **Clinical Facilities' Administrators**, whether of area hospitals, extended care speciality, or rehabilitation facilities, are usually sources of information and influence, thus meetings with them need to be conducted with care. The best approach, after clearly indicating that you are seeking information as part of a feasibility study, is to begin by asking whether from the administrator's standpoint there appear to be any allied health personnel needs in the area, and if so, in which fields. Using a checklist of the allied health fields, ask specifically about those professions that the administrator does not mention, when the type of allied health professional is employable by that facility. (The types of personnel employable by the facility can be determined by viewing its service departments during a tour.) Other questions that should specifically be asked are as follows:
 - Does the facility itself offer any allied health training programs? If so, which?
 - Are students from any collegiate allied health programs now receiving their clinical training at the facility? If so, which?
 - What is the general attitude of the facility toward student training?
 - Are there any departments in the facility that would be particularly interested in and/or appropriate for student training? If so, which?
 - If the college or university were to start allied health programs, would the administrator be interested in the possibility of students using his/her facility for training?

Particularly with facility administrators, it is important to record in your notes their attitudes as well as the information given. Frequently the attitude of the administrator is

reflected by others who work at the facility, and thus can be an important factor in determining whether a supportive attitude for student training would be likely to exist.

If the facility administrator suggests that specific departments would be appropriate for training, use that opening to ask the name of the head of the department, and whether the administrator would be willing to have you speak to that individual. Request, directly or indirectly, the privilege of returning to the facility for further information and/or meetings with facility personnel.

- **University Health Science (Medical) Centers** that offer allied health programs may have collected some regional or state manpower data and may be willing to share it. The dean or director of allied health is the person to contact for this information.

State: Two types of state-level groups may have allied health manpower data for particular professions, i.e., state professional associations and, when they exist, state licensure boards. Requests for the names of individuals to contact in these groups and their addresses can be obtained from the national association for each allied health profession. State boards or commissions of higher education occasionally collect manpower information from a number of sources; since their information presumably will be gathered from the same primary sources from which you will have gathered it, the dates and the specific sources should be examined critically.

National: Two major sources of allied health information exist on the national level, i.e., the professional associations and the U.S. Department of Labor, Bureau of Labor Statistics, which publishes a yearly *Occupational Outlook Handbook*, available from the Government Printing Office for about \$15. *The Health Professions* (see p. 11) is another publication which has synthesized much available national data for allied health fields.

Existing Allied Health Programs in the Region and State

It is important to know exactly which allied health programs are offered in the area, both by the community colleges and by other senior-level educational institutions, as well as by the hospitals. Information regarding programs in educational institutions is easily obtainable from their catalogs. For state-supported institutions, it will also be necessary to determine what other institutions within the state system offer which allied health programs. It would be helpful to meet with the dean or director of allied health at each of the institutions that have potential impact on your institution's efforts so that you can determine their future plans for allied health activities; any problems they are having with regard to present programs; and whether they currently have linkages with other institutions or would consider forming such linkages.

Institutional Strengths and Weaknesses

In order to facilitate information gathering and institutional assessment, an *ad hoc* allied health advisory committee chartered by the individual conducting the feasibility study can

be formed. Members of the committee should be drawn from each of the science departments, the mathematics department, the student recruitment office, and the central administration, as well as others who might have a potential involvement in future allied health activities.

Many factors, both tangible and intangible, increase the likelihood that allied health activities undertaken within the institution will be successful. The primary factors that are likely to contribute to an institution's ability to both undertake and conduct such activities can be considered by asking and answering the following questions:

Institutional Administration and Other:

- Does the administration have the flexibility to deal with programs that are markedly different from other institutional programs?
- Is the administration willing to strongly encourage cooperation from the rest of the academic community in initiating allied health activities?
- Can the institution form a new department or other academic unit for allied health programs?
- Are allied health programs consonant with the mission and objectives of the institution?
- Does the institution have a record of good relations with community agencies and personnel?
- Does the institution have cooperative arrangements with other educational institutions?

Financial:

- Does the institution have the flexibility to offer competitive salaries to allied health faculty and program directors that may be higher than others of the same academic rank within the institution?
- Does the institution have sufficient funding or potential funding (internal or external) to support allied health activities, including both start-up and maintenance?

Facilities:

- Is there sufficient space among the institution's buildings to house new faculty and single-purpose laboratories?

Students:

- Does the institution attract sufficient numbers of academically strong students for allied health programs?
- Is there now or is there the potential to be strong student interest in allied health professions?

Science Curricula:

- Are the science curricula offered by the institution rigorous and up-to-date?

- Are science courses offered that have a human or health orientation, exclusive of those offered by or for physical education? Do such courses (e.g., human anatomy and physiology) count toward an academic science major?
- Are such courses as microbiology and biochemistry available at the sophomore or junior level for nonbiology and nonchemistry majors respectively?
- If the answer to either of the previous two questions is negative, are there sufficient numbers of faculty and sufficient laboratory space and equipment to design and offer such courses?
- Are the science faculty supportive of the initiation of allied health activities?
- Would the science faculty be willing to assist in allied health career awareness/student recruitment activities, even if it meant fewer student majors in their own disciplines?
- Are the science faculty willing to teach service courses for allied health students? Are they willing to have such courses count toward an academic science major?

Faculty:

- Will the institution and its geographic location be attractive to potential allied health program directors and faculty?

C. Program Cost Considerations

Because cost is an area of considerable concern to most colleges and universities, it is recommended that you read the "Financial Considerations" section of "New Programs" of this document. The section includes information pertaining to both start-up and maintenance costs for specific allied health programs.

D. External Influences

The external factors—local, state, and national—that impact upon the development of the allied health activities of an educational institution are numerous and important: they can either enhance or virtually preclude the success of the activities.

On the local and regional level, clinical facility administrators, as already discussed, are critical in making available facilities for student training and encouraging the cooperation of their professional staff. Within clinical facilities themselves, the support of physician and allied health professional personnel are crucial if they and their physical facilities are used in student training. Especially in relatively isolated geographic areas where teaching opportunities are few, both allied health professionals and physicians may, even at this early stage, offer their services as program administrators or faculty. While applauding and making formal note of their interest, it is clearly premature to make any commitments to area professionals at this stage. It is important to remember that program accreditation standards usually dictate the qualifications of allied health directors and faculty.

Local or regional HSA's, and medical and allied health professional groups should also be informed of the institution's intention to conduct a feasibility study, and be invited to lend support.

On the state level, two groups may be particularly important, i.e., state allied health professional associations and state boards or commissions of higher education. State allied health professional associations generally remain neutral or are supportive of institutional considerations of program initiation. *(The only formal opposition from such groups that we encountered in the course of the project occurred in states where there existed only a virtual handful of practitioners in a specific allied health profession, that is, there was a severe shortage. The motive behind such opposition, we were informed, was a desire by practitioners to maintain the high salaries that the shortage had created. Opposition from these several groups quietly and quickly ceased after informal discussions were held between project staff and the appropriate national professional associations regarding the stance of state groups.)*

State boards or commissions of higher education, while usually having no control over private colleges and universities, can present a hurdle for state institutions. The primary difficulty is the fact that in most states allied health programs, sufficient in the eyes of the state boards to meet state needs, have in effect already been divided among majority institutions, especially those that offer medical and other health professions programs (i.e., academic health science centers). As a result, state boards are often reluctant to authorize new allied health programs at state institutions of higher education. The strongest argument that can be made to these boards is the dearth of minorities being trained in existing programs.

National level allied health professional associations generally also serve as the program accrediting agency, or cooperate with the American Medical Association (AMA) in doing so. It is quite important to make contact with the educational directors of these associations early on. These individuals can be helpful in suggesting consultants and program directors and faculty, as well as assisting an institution through the lengthy process of obtaining program accreditation.

E. Decision Making

After gathering the requisite internal and external information, and comparing the results against the allied health program curricular and clinical requirements of the accreditation "essentials" and the financial considerations presented in this document, preliminary decisions should be made with regard to what allied health activities the institution might or might not best initiate. (A sample feasibility study is attached as Appendix E.) In making these preliminary decisions, it is best to remember that it will be most efficient financially and in other ways if new programs have a common theme. For example, physical therapy, occupational therapy, and speech pathology are rehabilitative in orientation, and thus have courses in common; these programs would have few courses in common with medical laboratory fields or medical records administration.

After preliminary decisions regarding allied health activities are made, it is *strongly* recommended that the services of a qualified consultant be secured for each type of allied health program being considered for initiation. Consultants should not be used to design a program's curriculum (that will be the job of the program director, when hired). Rather, the consultant should provide more detailed information regarding the institutional and external resources that a particular allied health program will require than can be given in the feasibility study. Specifically, the consultant should provide the following in a formal report:

- Determination of the adequacy of area clinical resources for student training, and the willingness and ability of clinical personnel to assist in student training;
- Assessment of existing science courses for the preprofessional portion of the curriculum;
- Preliminary determination of program needs, i.e., new preclinical and clinical courses, new faculty, facilities and equipment, and approximate costs for these additions;
- A realistic timetable for implementation of the program.

It is very important to utilize the services of consultants who are both knowledgeable and influential within their own fields. These qualifications are stressed for several reasons. First, the credibility of an institution's activities with other educators in a field will initially rest on the credibility of the consultant. Second, highly capable and influential consultants will usually be both willing and able to continue to assist the institution (often without charge) in its efforts to recruit faculty and in other activities required for the initiation of allied health programs.

It should be anticipated that consultants will require two-three days on-site and one day to write the report. Consultant fees will be approximately \$200/day plus travel and per diem costs. Letters of appointment sent to consultants should spell out all conditions and expectations.

Suggestions for consultants may be obtained from the professional associations. A list of recommended consultants is also attached as Appendix F. (The individuals on this list were found, during the course of the project, to be quite successful in working in minority settings and in preparing the types of reports described.) A sample consultant's report is attached as Appendix G.

With the completion of both the feasibility study and the consultant reports, the central administration should be able to make informed decisions regarding whether to initiate new allied health programs, and if so, which programs, program timetables, and approximate budgets. After these decisions are made, consideration of cooperative programs and improving existing programs may be made. Each of these considerations will be covered in succeeding sections.

SECTION III. NEW PROGRAMS

A. Introduction

After an institution has conducted its feasibility study and obtained positive consultant reports regarding the implementation of specific new allied health programs, the early or planning phase of actual implementation can begin. For public colleges and universities, this stage usually involves filing the appropriate "declaration of intent to begin a new program" with the state board of higher education. In addition, both public and private institutions usually need to file statements of declaration of intent with the appropriate professional (accrediting) association(s).

B. Timetable for Implementation

The early stage of the implementation phase of new allied health programs usually becomes a juggling act of recruiting students, recruiting a program director and faculty, anticipating preclinical requirements, and obtaining the necessary program approvals. Even under the best of circumstances all of the required elements may not fall into place at the times that they should, but at the least a realistic timetable and plan for program implementation will be a crucial beginning. The consultants' reports should be invaluable in helping to establish such timetables. A typical timetable for the development of a baccalaureate-level allied health program or programs is outlined below:

Year 1

- Develop feasibility study;
- Obtain consultant report(s);
- Make institutional decision regarding which program(s) to undertake;
- File intent to initiate new programs with state board of higher education and professional (accrediting) association(s).

Year 2

- Advertise for, recruit, and appoint program director (and faculty as needed) for next academic year, appoint allied health advisory committee (if needed);
- Determine preclinical courses, facility, and faculty needs;
- Advertise program and begin student recruitment;
- Form allied health administrative unit (if needed);
- Renovate and equip preclinical facilities and allied health faculty offices, as needed.

Year 3

- Finalize preclinical curriculum and offer any new preclinical courses required;
- Program director and faculty (as needed) develop curriculum including obtaining contracts with clinical sites and personnel;
- File "declaration of intent" with accrediting agency;
- Recruit and appoint additional faculty for next academic year (as needed);
- Continue student career awareness and recruitment activities;
- Counsel students already enrolled in the institution and transfer students interested in the program;
- Determine the student application and selection standards and procedures, and select students (sophomores) to the program;
- Determine policies for program (e.g., insurance, travel);
- Renovate and equip clinical laboratories.

Year 4

- Offer first year of clinical portion of curriculum;
- Recruit and appoint new faculty (as needed);
- Accept second class of students;
- File "self-study" report with accrediting agency.

Year 5

- Offer (first and) second clinical years of curriculum;
- Accept third class of students;
- Graduate first class;
- Apply for accreditation site-visit and file final documents for accreditation.

There are myriad and often complex issues in the implementation of new allied health programs; no attempt can be made here to provide all the details of every aspect of each type of program. Rather, the objectives in this section are to (1) provide the reader with sufficient information regarding the process of allied health program implementation to allow him or her to proceed; (2) point out potential pitfalls in the process; and (3) provide detailed information in areas in which minority colleges and universities appear to be having the greatest difficulties (i.e., allied health career awareness/student recruitment and retention, financial considerations, and contractual arrangements).

C. Planning Stage

Campus Personnel and the Preclinical Curriculum

It is assumed that the campus-based individual who conducted the feasibility study will continue in the role of allied health coordinator. It is helpful at this stage if the individual is officially so designated. At this point the coordinator should be responsible for all of the activities designated as "Year 2" in the "typical" timetable presented above.

Assistance usually will be required by the coordinator in finalizing the preclinical curriculum; the campus advisory committee and/or the science faculty (and consultants, if necessary), plus the program director, if hired early in the year, should provide such assistance for the task. The preclinical curriculum *must meet the accreditation standards of the program(s)*. Further, the program director and faculty may want changes made in sequencing and/or content of the preclinical courses once the clinical curriculum is finalized; the institution must be flexible and prepared to make such changes, if needed.

In addition to anticipating precisely which courses, if any, will need to be added to the preclinical curriculum (usually the freshman and sophomore years), plans for space, equipment, and faculty for those new courses must be completed with the expectation that the courses will be offered during the following year. In relatively small institutions consideration of the impact of potentially greater numbers of students enrolled in the existing science and other required preclinical courses should also be made. As will be discussed, consideration should be given to initiating early on an "Introduction to the Health Care Fields" course for one or two credits and open to all students in the institution.

At this stage in development, science faculties typically become very agitated about the "impossibility" of the science requirements for students in allied health fields. The concern of these faculty is usually that (1) there is little, if any, health or human orientation to the present institutional science offerings; (2) prerequisite courses for some of the science offerings virtually preclude a student's completing the preclinical curriculum in two years; and (3) any new "watered down" science courses initiated for allied health students will not be allowed to count toward a science major.

Typically the dichotomy between the institution's present science offerings and those needed by allied health students is as follows:

Present Offerings	Courses Needed by Allied Health Students
Biology 101 Biology 102 (Both Introductory Biology)	Biology—one semester introduction
Chemistry 101 Chemistry 102 (Both General Inorganic)	Chemistry—one semester inorganic
Chemistry 202 Chemistry 203 (Both General Organic)	Chemistry—one semester organic
Chemistry 404 (Biochemistry) (requires Chemistry 202 & 203)	Chemistry—one semester biochemistry taken sophomore year
Biology 302 (Comparative Anatomy) (requires Biology 101 & 102)	Human Anatomy—one semester or combined with physiology

Present Offerings	Courses Needed by Allied Health Students
Biology 420 (Physiology)	Human Physiology—one semester or combined with anatomy, taken sophomore year, and one semester each of inorganic and organic chemistry as prerequisites
Biology 450 (Microbiology) (Both require Biology 101, 102, and Chemistry 202 and 203)	Microbiology—one semester taken sophomore year, with chemistry prerequisites as for physiology, above.

Mathematics and physics may also present similar difficulties with some allied health programs.

In most institutions, the addition of allied health programs results in the need to offer new human-oriented science courses having fewer prerequisites than existing science offerings. The alternative is to require an extra year or more for students in the preclinical portion of the allied health curriculum, a wholly unjustified requirement. A few institutions, unwilling to offer the new science courses which its allied health programs require, have rationalized their actions by declaring that students need the extra training that the additional year or year and a half provide. Students have the option of taking the lengthy route of courses offered for science majors, but also need to be able to take a preclinical curriculum that allows them to graduate in the normal four years. Further, the orientation of the preclinical science courses should be human and pragmatic rather than aimed toward theory and research, as is the case with most science courses offered for science majors.

It should also be indicated clearly to the science faculty that any preclinical science courses designed and offered for allied health students must be *at least* as rigorous as those offered for science majors. (The *level* of the subject offered is sometimes confused with the *rigor* of the course.) Physical education courses in anatomy and physiology are only rarely considered adequate for allied health majors. The science faculty should also be encouraged to work out ways in which students completing preclinical science courses can be given credit for those courses in an academic science major if the student does not enter the clinical portion of the allied health curriculum.

Allied Health Administrative Structure

The placement of allied health programs into an institution's administrative structure only rarely appears to create difficulties. Generally each program becomes a department within a division of sciences and mathematics, or of arts and sciences. If there are unresolved issues involving preclinical courses and/or the attractiveness of allied health programs to traditional science majors, difficulties can arise. A common complaint among allied health program directors placed in a traditional academic unit at whatever level is that the dean, vice-president, division chairperson, or whoever administratively heads the unit has no understanding of the needs of allied health, and thus does not provide sufficient support to the programs. It will best serve all concerned if the administrator of the unit is involved in all steps of

planning and implementing allied health programs in order to become as familiar as possible with the similarities and differences between allied health and traditional academic programs.

Institutions initiating several allied health programs (and/or which already have a nursing program) frequently form a division or school of health sciences, under the administrative aegis of a dean, director, or coordinator of allied health or health sciences. While the degree of autonomy that this arrangement provides for the allied health departments is usually quite beneficial, conflicts with nursing departments appear to occur with unfortunate and inexplicable regularity.

However an institution decides to position its allied health programs administratively, the decision should be made before a program director is hired, if possible.

Program Director/Faculty Recruitment

Perhaps the most difficult and important task during the planning stage for new programs is recruiting and appointing a qualified program director. Since the accreditation standards may dictate the director's qualifications, or at the least the accrediting agency will have certain unwritten expectations of qualifications, a meeting with the agency's educational director is crucial. In such a meeting, the following should be determined:

- The required or expected qualifications of a director;
- The average salaries and conditions of employment (academic appointment levels and lengths, for example) of education program directors in the field;
- Suggestions for specific individuals who might be interested in the position;
- Suggestions for groups to contact and publications in which to advertise the position. (Groups to contact, for example, would include state professional associations and area graduate programs in the field; publications in which to advertise include the professional journals, the *ASAHP Trends** and the *Chronicle of Higher Education***).

The consultant utilized for the feasibility study should also be contacted for suggestions of possible director candidates. Both the accrediting agency and the consultant should be used on an informal basis to assist in evaluating the curriculum vitae of applicants. (In addition to the required professional and academic degrees, the primary qualification of a director will be teaching and/or administrative experience in an academic setting.)

Once applications for the director's position are received and appraised, the wooing of qualified candidates can begin. Unlike many academic fields, the allied health fields usually have an acute shortage of director candidates; thus applicants will often need to be won over. Strategies that have been successful in recruiting allied health personnel include the following:

* ASAHP; Suite 300; 1 Dupont Circle; Washington, DC 20036.

***The Chronicle*; P. O. Box 19446; Washington, DC 20036.

- Paying for transportation and lodging costs of both the candidate and the candidate's spouse during the two-three day campus interview visit;
- Arranging for receptions, dinners, and other social events for the candidate (and spouse) that include the advisory committee, faculty and/or the board of trustees of the institution;
- Arranging for the candidates (and spouse) to meet with real estate agents who can show them property in which they might be interested;
- Providing the candidate with a university or rental car during the campus visit and for several days thereafter, if desired.

Salaries and types of academic appointments are major factors in attracting program directors. *Among project institutions successfully recruiting program directors, 12-month appointments without immediate tenure at the Associate Professor level and at an annual salary of \$34,000-\$42,000 appear to be usual. Those institutions that have attempted to recruit directors at salaries ranging from \$20,000-\$30,000 have had limited success.*

In the case of the formation of a relatively large and sophisticated new allied health program at an institution, the program director may express a strong desire to have one or two at least part-time faculty appointed for curriculum development, i.e., for Year 3 of the timetable. This request should be honored if at all possible. Recruitment of the faculty should be primarily the responsibility of the program director, once appointed, regardless of whether the director is physically present on the campus.

In recruiting both allied health program directors and faculty, it is extremely important that the *expectations* of both the candidates and the institution be carefully explored in order to avoid later claims of "bad faith." Specifically: what are the expectations of the institution regarding research, community service, and teaching loads; promotion and tenure vs. terminal degrees; central administrative involvement in the program and program support; program size; and student qualifications. While it is important in recruiting allied health program directors and faculty to put a favorable light on the institution, a lack of candor usually results in future misunderstandings.

Advisory Committee and Program Publicity

If several new allied health programs are planned, it would probably be helpful to appoint an *ad hoc* community-based advisory committee. (Some allied health programs are required by the accrediting agencies to form program advisory committees. Since the membership of such committees must be the prerogative of the program directors, it should be made clear that any advisory committee formed at this point will probably have limited tenure.) The primary function of the advisory committee should not be to make decisions regarding the program(s) or their curricula, but rather to give advice concerning where community roadblocks may occur and how they might be overcome. Representatives from the area HSA, medical society, and professional associations, as well as hospital administrators from all facilities crucial to the program should be appointed to the committee. Health care providers who have been particularly helpful to the institution's efforts can also be appointed: they can often continue to be helpful by privately pointing out potential political barriers not openly discussed by the

committee. The advisory committee can also give added visibility to a program, thus enhancing student interest. Institutions having such a committee often ask them to interview faculty and program director candidates, thereby giving the institution the opportunity to see how well the candidate interacts with health professionals, as well as giving a candidate the opportunity to gauge community support.

During Year 2 public announcements of the initiation of the program need to be made, and early efforts to recruit students for entry by Year 4 should be made. A mechanism for counseling and keeping careful records of interested students will need to be established.

D. Implementation

Once the program director (and faculty, as needed) is present on the campus, the actual implementation phase can begin. While the program director will have responsibility for all aspects of the clinical portion of the program curriculum, full responsibility for other aspects, including student health career awareness, the preclinical courses, and some political aspects can be shared with other allied health directors if more than one program is being developed, and/or with the allied health coordinator.

Faculty

Some considerable differences exist between allied health faculty and those in traditional academic fields. These differences usually begin to become apparent when recruitment efforts are initiated. Initial surprise at the time of faculty recruitment usually involves both salaries and terminal degrees. Just as program directors' salaries are generally higher than those of other (academic) departmental chairpersons, so also are the salaries of allied health faculty. (See "Financial Considerations" in this section for specifics.) In addition, in most undergraduate-level allied health programs a master's degree is the accepted terminal degree for faculty members. (The program director, on the other hand, is usually expected to have an Ed.D. or a Ph.D. in a related field.) The primary reason for this situation is that, with only a few exceptions, no Ph.D. programs exist in allied health disciplines, *per se*, and indeed, in a few disciplines (e.g., medical records administration) no master's-level programs exist in the field.

Appointment of allied health faculty, then, will usually be at a higher salary and a higher rank than other academic faculty at the master's-level. The higher salaries can be justified on several grounds, i.e., a shortage, their immediate employability in health care settings, and the fact that their teaching contact hours often are excessive (as many as 30 contact hours per week are not unusual).

The lack of Ph.D. degrees among allied health faculty also raises another dilemma, i.e., lack of research experience and publications. Only during the past few years have the various allied health disciplines begun to acknowledge the need for research in their own fields, and especially on the part of individuals located in academic settings. The allied health researcher still remains very rare, however. In those institutions that expect research of their faculty, special efforts will probably need to be made to overcome the inexperience of allied health

educators in research methodology and proposal preparation. Even with such special efforts, many institutions of higher education find allied health faculty reluctant and often unable, given the considerable contact hours required, to undertake independent research. Consideration will need to be given early on to the means by which allied health faculty will be evaluated within the context of an institution's promotion and tenure policies.

Health science, allied health, and nursing faculty often have some difficulty understanding and adjusting to the academic milieu. Their heavy teaching responsibilities also generally preclude much interaction with collegiate peers outside of their own program. The usual result is a sense (and often an actuality) of professional isolation as well as of mystification at the academic process. Especially in those institutions having only one or two health science programs, this sense of isolation can result in serious difficulties which should be anticipated before they appear. Efforts will need to be made to include allied health faculty on college-wide committees and in social and professional functions of the institution. Also, frank discussions about the academic traditions of consensus and collegiality vs. the health care tradition of hierarchies and authoritarianism are sometimes helpful.

The allied health faculty will need to be strongly supported by very good clerical help; program accreditation requires careful, extensive, and secure record-keeping as well as the preparation of lengthy self-studies and other reports. Allied health programs, too, because of their dependency on outside facilities and personnel and their student recruitment activities, have considerably more correspondence than does the average institutional department. Therefore it is advisable, if at all possible, to have a full-time secretary for each program; if the programs are small in terms of number of students and faculty, then one secretary for two departments may suffice.

Faculty development and funds for allied health faculty to attend professional meetings are *crucial*. For the faculty to keep abreast of new technologies and methods in a field as dynamic as health care, attendance at one or two out-of-town meetings and several local meetings per year will usually be required. (Indeed, continuing education experience may be required for continued practitioner certification.) Ideally, the faculty of an allied health program will be sufficiently abreast of changes in their field that they and their students will provide new information to professionals in the clinical sites where student training occurs.

Health care professionals in student training clinical sites who have direct responsibility for students are generally granted adjunct professor status. While such individuals are not usually paid, their adjunct status should give them such privileges as use of the college library and sports facilities, as well as additional perks granted to other institutional faculty members. A yearly campus reception in their honor or other social recognition of their contribution to the program can be held.

Curriculum

As has been indicated, allied health program curricula are usually divided into two parts: the preprofessional (or preclinical) portion which usually occurs during the freshman and

sophomore years, and the professional portion which occurs during the junior and senior years. In most institutions students apply for acceptance into the professional curriculum; generally the application and selection process occurs during the sophomore year.

The Preprofessional Curriculum consists of science and social science courses plus general education courses required by the institution. The mixture of courses taken in the first two years will vary from field to field, and to an extent to the degree dictated by the program accrediting agencies. Obviously those fields with a greater science orientation, such as medical technology, will require more mathematics, biology, chemistry, and physics courses than those professions with a greater social science or systems orientation, such as mental health technology and medical records administration. Some specialized sciences courses, as for example neuroanatomy and respiratory physiology, offered for physical therapy and respiratory therapy students respectively, may be taken concurrently with the clinical curriculum in the student's junior year. A very limited number of education requirements may also be taken during the junior and senior years. (Most institutions require the same number of general education credits of its allied health students as of other students.)

For institutions that offer several allied health and nursing programs and/or offer the preprofessional curricula for at least some programs in collaboration with another institution that offers the professional curricula, the development of a health sciences "core" is usually effective and economical. The "core," a group of courses required of all health science students, will vary from institution to institution depending mostly on which professional programs it is preparing students for. A core curriculum for an institution offering several health science programs including medical technology and physical therapy might be as follows:

Freshman Year

<i>First Semester</i>	<i>Credits</i>	<i>Second Semester</i>	<i>Credits</i>
Introduction to Biology	4	Human Anatomy	4
Introduction to Chemistry	4	Organic Chemistry	4
Basic Mathematics	3	Mathematics	3
English	3	English	3
Introduction to Psychology	3	Human Development or or Social Studies	3
		Introduction to the Health Care System/Professions	1-2
Total Credits:	17		18-19

Sophomore Year

<i>First Semester</i>	<i>Credits</i>	<i>Second Semester</i>	<i>Credits</i>
Biochemistry	4	Instrumental Analysis*	4
Computer Science	2	Introduction to Physics	4

* for medical technology students.

Sophomore Year cont'd

<i>First Semester</i>	<i>Credits</i>	<i>Second Semester</i>	<i>Credits</i>
Human Physiology	4	Cell Biology*	4
English	3	Microbiology* or Advanced	
General Education requirement	3	Physiology, Neuroanatomy, or other science	4
Medical Terminology	1-2	Medical Ethics	1
Introduction to Medical Technology, Physical Therapy, or other allied health field)	1-2		
Total Credits	18-20		17

Institutions that do not offer advanced science courses (e.g., neuroanatomy) may need to hire a part-time faculty member from a nearby health science (medical) center to teach such courses, although it is clearly advantageous to have this capability internally, if possible.

The professional curriculum of an allied health program, as indicated, is usually taught during the junior and senior years of a student's program. (Some "integrated" programs offer professional components throughout most or all of the four years.) Institutions and programs vary in the degree to which students train off-campus during this phase of the curriculum. What must be taught on the campus are basic skills in the profession. Teaching basic skills will require a single purpose laboratory having the same essential equipment as is found in a practice site. Particularly in rehabilitation fields, the basic skills laboratory can also double as an area of patient care during limited scheduled hours. (*Chicago State University, for example, is establishing a rehabilitation therapies lab to be used by physical therapy and occupational therapy students as well as to serve patient/clients*). Some medical laboratory technology programs in universities use simulated clinical labs set up on the campus for their students.

In addition to basic skills, essentially all allied health fields require further training of students in actual sites of patient care. The sites are selected by the program director and faculty on the basis of the type of care provided by the facility (thus, the type of learning experience that the student will obtain), the qualifications and expertise of professionals practicing in the facility, the willingness of the facility to have student trainees in areas of practice, the proximity of the facility to the college or university, and sometimes other factors dictated by the accrediting agency. Clinical training sites may be general or speciality hospitals, nursing homes, ambulatory care centers, rehabilitation centers, or others, depending on the field.

* for medical technology students.

Student training in clinical facilities is no longer the sort of loose and lengthy apprenticeship that it once was: student learning experiences and functions are now explicitly defined and supervised, and specific arrangements and expectations between the educational institution and the clinical training site are carefully spelled out in contractual arrangements. Again, cognizance of the accreditation essentials is crucial in making arrangements with clinical facilities for student training, since a number of aspects of the training are specified by the essentials. (For example, respiratory therapy essentials require a 1:5 faculty/student ratio in laboratory training, while those of medical technology specify a 1:10 ratio.)

Transportation for students to and from clinical training sites is sometimes provided by the educational institution in a bus, van, or college car. This can become both expensive and logistically difficult with large classes of students, groups of whom are training at different sites concurrently. The more usual mode of handling transportation is to require students to have cars or otherwise provide their own transportation.

Clinical Affiliation Agreements

The issue of contractual agreements with clinical facilities where allied health students are being trained is one that usually needs careful consideration and attention. (Even institutions that have abrogated the responsibility for clinical training of students to other educational institutions or to hospital training programs will need to consider what contractual agreements must be developed.) The general concepts that underlie such contractual agreements, as well as specific areas that need to be addressed are included in Appendix H. A sample agreement is also included in the appendix.

Program Accreditation*

As has been indicated, virtually all of the mainstream allied health programs have accreditation standards or essentials and one or more accrediting agencies. (Institutional accreditation has no bearing on allied health program accreditation, except that usually it is required for program accreditation.) The largest allied health accrediting group, recognized by both the Office of Education and the Council on Postsecondary Accreditation (COPA), is the AMA's Committee on Allied Health Education and Accreditation (CAHEA): CAHEA, in conjunction with other professional groups, accredits 25 types of allied health programs.

While the process of accreditation is usually described as "voluntary," in the case of allied health, program accreditation is essentially mandatory since usually it is required for graduates to be eligible to take certification exams—the exams themselves usually being required for practice.

Program accreditation essentials tend to be quite specific and may include standards for such things as space and equipment allocations, faculty and director qualifications, curriculum content and/or objectives, and financial support for the program.

* "Program Accreditation" contributed by Winifred Mauser, M.S., Assistant Professor of Physical Therapy, Beaver College.

Gaining program accreditation usually is a three-step process. Immediately after the decision is made to initiate a program, the accrediting agency should be so advised in a short letter. The second step, filing a formal application for accreditation or compiling a declaration of intent, can be either simple or detailed depending on the accrediting agency. Usually, applications for accreditation require only basic information about the program, e.g., identification of program administrators, degree offered, type of program, and so forth. Declarations of intent, on the other hand, tend to require greater programmatic detail, including descriptions of the complete curriculum with course outlines and objectives. The program director is responsible for completing the declaration of intent; often this process requires six months or so. (Complicating the institution's efforts is the fact that some agencies require the document to be submitted six months prior to admitting the first class of students.)

The third step in the accreditation process, the self-study, occurs during the first year in which students are enrolled in the professional training portion of the program. For the self-study report, faculty are usually required to undertake an internal review comparing the program structure and objectives with accreditation essentials. Input is also sought from students, academic administrators, and clinicians, and detailed descriptions of all curricular activities are required. (The accrediting agency provides written materials to direct the self-study process.) An accreditation fee may be levied at this time. The amount and complexity of the information required for the self-study make this phase of accreditation the most lengthy one: six months to a year is the average time required to compile the report.

Upon receipt of the self-study report, the accreditation agency usually schedules a site-visit to the institution. The number and composition of the site-team members will vary, depending on the accrediting agency involved. Generally the composition of CAHEA site-visit teams includes an allied health educator, an allied health practitioner, a physician knowledgeable about the occupation, an AMA staff member, an educational director of a similar program, and a dean of an allied health college that includes a similar program. A site-team member may, however, fulfill more than one role.

Site-team members will evaluate all facets of the institution's program, not just the content of the professional component of the program. Therefore, academic administrators who are interviewed need to be familiar with accreditation essentials; administrators will also be required to show in what ways and to what extent the institution supports the program.

Site-visit teams will vary in their capability and flexibility, but not infrequently they have difficulty understanding and judging programs that in any way deviate from "the norm." Institutions that have a unique mission and/or approach to allied health education will need to plan to fully and openly discuss the issues of uniqueness, stressing the fact that uniqueness does not adversely affect the quality of the program or its graduates. A strongly positive and persuasive attitude in this regard should be maintained throughout all negotiations with the site-visit team.

Prior to leaving the institution the site-visit team will present an oral report of its findings. Everyone directly involved in the program should attend this presentation, including program

faculty, students, faculty from science and other departments, supporting institutional administrators, and practitioners from the community. Having a good "turn-out" for the report further demonstrates interest and support for the program.

Administrators will have the opportunity to respond to any factual errors in the report both at the time of the oral presentation and later, after receiving a written copy of the report. A common temptation in situations where the institution is in disagreement with the report findings is to respond to the report in an argumentative and defensive manner. Any response to the accreditation agency or to site-visit team members must be done by presenting factual information and delivering it in a nonthreatening manner.

After the accreditation agency is in receipt of the self-study report, the site-visit report, and the institution's response, if any, to it, the documents will then be evaluated by the accrediting committee. For new programs, the usual accreditation options are either accreditation or accreditation withheld.

Graduate Credentialing

As indicated, in many allied health fields in many states, credentialing of graduates from accredited programs is required in order for them to practice in the field. *Credentialing is a general term that is used to refer to any of the processes of certification, registration, or licensure.* Generally, certification and registration refer to nongovernmental processes involving passage of a qualification examination. Licensure, on the other hand, is a state-administered process used in those health professions in which state laws require certain qualifications and passage of a licensure exam for practice.

In designing an allied health program curriculum, it is crucial to have an understanding of both accreditation essentials and the types and levels of the credentialing exams that will be required of graduates. The reputation of programs is, fairly or unfairly, based to a large extent on graduates' ability to pass licensure and certification exams; thus it is crucial to monitor closely these results each year. Passage rates of the exams of less than 85 percent should be viewed with alarm (see Section V, "Allied Health Program Improvement," for further comments on low graduate passage rates).

Political Considerations

Health care, whether on local, state, or national levels, is political. It is not surprising, therefore, that health professions education is also influenced by political factors. Many of these influences have already been mentioned, i.e., local, state, and national professional associations, HSA's, state coordinating boards, or commissions of higher education, health care facility administrators, accrediting agencies, and licensure boards. It cannot be overemphasized that one of the primary differences between the traditional academic programs of an institution of higher education and all health science programs is the degree to which outside groups and agencies are directly or indirectly involved in the approval, running, and success of the health science programs. Minority colleges and universities in the past have sometimes been reluctant to acknowledge the importance of these political influences, and thus have

failed to deal with them appropriately. The specific results of failing to deal with the political factors have been instances of denial of approval to initiate allied health programs, inadequate support from community and clinical facilities' personnel, lack of financial support for the programs in state-supported institutions, and loss of or denial of program accreditation. In short, *all* political factors must be dealt with in order for the programs to be successful, whether in a majority or minority institution of higher education. And again, whatever the racial or ethnic composition of the student population in a college or university, some of the political factors will be in opposition to the institution's efforts. If opposing efforts are sufficiently vigorous, initiation of the programs can be delayed but rarely stopped completely if the institution is absolutely committed to its course of action. Institutional commitment, must, however, include marshalling the strengths of its faculty, central administration, and occasionally board of trustees, students, and alumni, as well as external contacts, to help offset or remove political opposition.

*E. Financial Considerations for Allied Health Profession Education Programs**

Allied health program costs are divided into two phases: start-up and ongoing. Start-up costs include all expenditures associated with the planning and development of the program prior to accepting students. Specifically, start-up costs entail (1) hiring consultants to assist with a feasibility study; (2) determining the structure and size of the program and faculty; (3) recruiting and hiring a program director to develop the curriculum and make preparations for program accreditation; (4) preparing space (e.g., specialized facilities) for laboratories; and (5) purchasing capital equipment, instructional materials, and library holdings specific for program needs. The "out-of-pocket" expenditures required to start a new program will vary greatly, depending on what is already available at "no additional cost." For example, if classroom, office, and appropriate laboratory space is available in a structurally sound and well-maintained facility, then no additional cost may be necessary for renovation. Allied health consultants can be helpful in identifying and estimating the start-up costs for the institution.

Cost is a relative measure. Although external agencies, such as accrediting groups, place certain constraints on the curricular content and equipment necessary to run a program, there is still a respectable degree of latitude possible in structuring allied health programs. Before deciding on a program structure, the key costs factors should be identified and a variety of program structures described in detail so that comparisons can be viewed and decisions made relative to the cost benefit of the various options. An effective and efficient process for planning a new program is to:

- Identify and examine the key variables affecting the operating costs of the program;
- Collect all feasible data for each key variable;
- Construct the operating costs of each option;

* Prepared by Meredith A. Gonyea, Ph.D., President, The Center for Studies in Health Policy, Inc., Washington, DC, edited by Mary Lee Seibert, Ed.D., Dean, College of Allied Health Sciences, Temple University.

- Compare projected costs with current sources of support;
- Select a cost-beneficial option for implementation;
- Develop a phased plan for use of resources;
- Prepare a financial plan to include costs and allocations for starting, implementing, and maintaining the program.

Following is a list of the key variables affecting the ongoing or maintenance costs of allied health programs and a discussion of the characteristics and relationships of each variable. The detailed procedure for analyzing each of these variables and constructing the overall cost of programs incorporating each of the variables is available from The Center for Studies in Health Policy, Inc., Suite 1000, 1100 17th Street, N.W., Washington, DC 20036.

Key Variables Affecting Allied Health Program Cost

Strategic planning for resource allocation and use and for financing allied health education programs is aided by identifying all variables affecting the resource requirements and costs of such programs. Table 1, the Program Costs Analysis and Construction Method (PCACM), KeyValues chart, summarizes information for the variables having major influence in the cost-benefit analysis of allied health programs. Emphasis for assessment of costs is placed on the primary academic unit responsible for teaching the professional component of the program; however, included is the recognition that other academic units of the institution provide portions of the curriculum (e.g., science and humanities courses) and, therefore, incur costs.

School: The name or type of the overall academic unit provides an indication of the environmental setting for the program. The academic placement of a program, such as in a School of Liberal Arts or a School of Allied Health, gives a "situational" perspective when comparing programs. Consideration of academic placement can influence cost if there are intrainstitutional differences among academic units in teaching loads, research requirements, faculty/student ratios, faculty qualifications, and faculty salaries.

Program: The program name identifies the allied health professional discipline, e.g., occupational therapy. For purpose of cost construction and for further discussion in this section, the program unit is considered to be the primary unit responsible for teaching: Teaching Responsibility Unit (TRU) #1.

Degree Awarded: The degree to be awarded must be identified. In most allied health programs, the degree level is standardized at a particular level and any program seeking accreditation must offer that degree. However, there are some allied health programs that may be offered at either the associate degree or baccalaureate degree levels and will allow graduates to qualify for the same professional credential, e.g., respiratory therapy and radiography. An institution should identify any options that may be available and make the decision regarding the degree award level based upon consideration of institutional mission, student needs, and program costs.

TABLE 1: PCACM KEY VALUES CHART – GROUP ONE

Allied Health Baccalaureate Program with a Primary Academic Teaching Unit

School	State University
Program	Allied Health
Degree Awarded	B.S.
Program Organization:	4 years
Academic Session:	Semester
Length:	128 weeks
Student Contact Hours: Program Total	3,584
% of Total SCH in TRU No. 1	50
TRU No. 1 SCH % in:	
Lecture	18%
Laboratory	18%
Clinic	64%
Average SCH/Week	28
Student: Class Size	32
Faculty Contact Hours: Program Total	6,893
% of Total FCH in TRU No. 1	81%
Average FCH/Student Output	215
Faculty Availability	
TRU No. 1 Full Time: Hrs/Week	15
Wks/Year	32
Hours/Year	480
FTE Faculty Required	
TRU No. 1 Full Time	11.6
Faculty Salary	
TRU No. 1 Full Time	\$25,000
Cost Factor: TRU No. 1	
Faculty Cost % of Total Cost	45%
Other Cost Factor	1.22
Average Cost per FCH: TRU No. 1	
Faculty Cost	\$52
Other Cost	\$63
Total Cost	\$115
Average Cost per Student per Year	
TRU No. 1	\$5,029
Total Program	\$6,288
Average Cost per Student Output	\$25,150
Attrition Rate	
Average Cost per Graduate	\$25,150
% Above Cost/50	

Source: CSHP: MAG: 5/7/82

Program Organization: Resource requirements and cost are affected by program organization. The longer a program is, the more expensive it will be when all other variables are constant. Cost-sensitive values are (1) the number of years in a program; (2) the types of academic sessions (semesters vs. quarters); (3) the length of the session types (16 weeks for Fall, 8 weeks for Summer); (4) the number of sessions required to complete the program. Normally, the academic structure of an institution is set. The type of degree an institution will offer may also be set (and unalterable) and will determine the number of years in a program. The number of program sessions may be the only potentially variable option.

Student Contact Hours (SCH): Curriculum design establishes the number of hours a student is scheduled to be in contact with a faculty member. Answering the question: "What amount of a student's time should be spent with the primary professional faculty?" is useful information to have in constructing program costs. How that (TRU #1 time) is distributed in large group (lecture), medium group (laboratory), or small group (clinic) size modes of instruction affects both the quality of the learning experience (benefit) and the resource requirements. The higher the percentage of SCH in TRU #1 or in small groups, the higher the cost. This relationship represents quality vs. cost balancing situations. An average SCH per week value is included to make a planner focus on the question, "What is a reasonable loan for the student?" The higher the student contact hours per week, the greater the stress is on the student and the higher the resource requirement and cost are.

Students: Class size is a critical factor in establishing the efficiency of the program. Determining class size should be made by identifying the maximum number of students that can be taught by one instructor in the mode of instruction requiring the smallest group size. For example, in a program where the maximum group size for one instructor in a laboratory is 16 students, the number 16 should be considered as the multiplier for efficient operation of the program. Such a program might accept 16, 32, or 48 students per class, assuming that for each group of 16 students a separate laboratory section would be offered at maximum efficiency. Lecture sessions could be offered only once for all 48 students. A common mistake made by program planners is to arrive at an arbitrary class size of, for instance, 24 students. In this example, the class would have to be split into two sections of 12 students each for laboratory instruction, leaving an "excess availability" in each laboratory section of four student slots. The revenue lost by having those four spaces vacant will drive the cost of instruction per student up and markedly decrease overall instructional efficiency. The PCACM is valuable in exploring options for expanding or contracting class sizes and for assessing the impact of doing so upon program efficiency. Other factors such as attrition, repetition, and the potential for students to transfer out of or into the program need to be considered if they could potentially change the class size to any great degree.

Faculty Contact Hours (FCH): For purpose of cost construction, faculty *contact* hours are used rather than *credit* hours, because the actual time spent in teaching a credit hour can vary depending upon the nature of a course, e.g., lecture, laboratory, or clinical supervision. The number of faculty contact hours required in a program is determined by the number of student contact hours necessary, the number of students in a group, and the class size. For example, a laboratory course requiring 45 student contact hours with a maximum group size of 16 students and a total class size of 32 students would require 90 faculty contact

hours (2 groups times 45 contact hours per group). To arrive at a faculty contact hour total for an entire program it is necessary to (1) calculate the number of student contact hours in each course in the curriculum; (2) multiply that number for each course by the number of sections of the course required to teach all the students in the class; and (3) sum the number of contact hours for all courses. To determine the number of faculty contact hours required by allied health program faculty (TRU #1), perform the above calculation separately for courses in TRU #1 and for those taught by other faculty. The percentage of total FCH in TRU #1 is determined by calculating the proportion (%) that TRU #1 is of the FCH in the total program. The average FCH/student output is a unit measure used to factor out the effect of class size and is calculated by dividing the number of faculty contact hours by the number of students taught. The number in Table 1 (215) represents the total FCH (6,893) divided by the class size (32). This variable is useful in comparing programs of different sizes as the DEMAND for faculty resources.

Faculty Availability: The SUPPLY of faculty time available for direct contact teaching is the focus of this variable with emphasis on the full-time faculty member in the primary department (TRU #1). The need for critical mass and the possibility for using multiple types of faculty is recognized but not presented in detail in this summary. (Critical mass is the minimum number of faculty required to teach any allied health program, regardless of class size. The smallest critical mass in allied health programs is ordinarily three professional faculty members.) The hours per week devoted to teaching and the number of weeks available determine the total number of hours available from any one faculty member for direct contact teaching. This type of information helps to respond to the question, "What is a reasonable teaching load for a faculty member, considering their other professional activity requirements, and how will changes in the load affect the SUPPLY?" The lower the total hours per year available for teaching from any one faculty member, the more the faculty that will be required and the higher the cost. There is no universally acceptable teaching load for allied health faculty, but commonly the teaching load for allied health programs in four year institutions ranges from 12 to 15 hours per week.

FTE Faculty Required: When the FCH DEMAND is divided by the FCH SUPPLY (availability), the FTE faculty required is determined. For example, if TRU #1 FCH equals 81 percent of the FCH for the total program (6,893) then the FCH for TRU #1 is 5583. If one faculty member is available to teach 480 hours per year, 11.6 FTE faculty are required to cover all teaching responsibilities in TRU #1. The minimum critical mass question is relevant when considering this variable. Starting with the question, "What is the minimum of professional allied health faculty (headcount) needed to start a program?" use of the PCACM will produce the options for class sizes in the program and allow decision makers to compare the costs of each option.

Faculty Salary: The average faculty salary (*without* fringe benefits) should be used as the variable when calculating program costs by this method.

Cost Factor: When the FTE faculty required is multiplied by the faculty salary the faculty cost for TRU #1 is determined. It is recognized that faculty cost represents only a portion of the total cost of operating a program. There are other costs, such as fringe benefits, space,

staff support, instructional materials, travel, etc. The magnitude of these other costs affects the total program cost. Data from a national study of allied health program costs have indicated that the "Other Cost Factor" is approximately 65 percent of the total cost, with faculty salary comprising only 45 percent of the total.

Average Cost per FCH: To determine the average cost per FCH, first multiply FTE faculty required (11.6) times faculty salary (\$25,000/year) to get \$290,000 per year in faculty cost. Then calculate the "Other Cost Factor" by multiplying the total faculty cost (\$290,000) by 1.22 (Other Cost = 65 percent of Total) to get \$353,800 per year in "Other Costs." Complete the calculation of average cost per FCH as follows:

Average Faculty Cost/hour:	$\$290,000 = \$52/\text{hour}$ 5,583 hours
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Average Other Cost/hour:	$\$353,800 = \$63/\text{hour}$ 5,583 hours
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Average Cost/FCH:	\$115/hour
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The average cost per FCH variable is useful in comparing programs with differences in student contact hours, class size, and classroom: laboratory: clinic organizations of the curriculum.

Average Cost per Student per Year: This variable is also a unit measure for comparison purposes. Only a portion of the background data has been presented, so it is not possible to show calculations for the dollar figures in Table 1 under this variable. In summary, however, the calculation of average cost per student per year would be made by multiplying the FCH by the cost per FCH and dividing by the number of students in *all* years of the program. It should be noted that averaging across four years of baccalaureate program results in some distortion. If the professional portion of the curriculum is placed primarily in the last two years, those last years are likely to be much more costly than the first two.

Average Cost per Student Output: This variable is recommended as a resource to the question, "What does it cost to educate a student?" and may lead to a discussion of the question, "Can we afford it?". The cost is calculated by multiplying the average cost per student per year by the number of years in the program.

Attrition Rate: This variable identifies the amount of reduction in the original class size related to the number of students who graduate. If a program is organized and staffed to provide resources for a full class size, then the higher the attrition rate, the higher the cost.

Average Cost per Graduate: This variable is a unit measure based on actual student output, graduates vs. potential student output, entering class size. The effects of attrition, repetition, and transfers are taken into consideration. The variable "Percent of Above Cost per Student Output" identifies the magnitude of the attrition rate on the cost of educating a student.

Program Cost Constructions: Allied health programs are divided into two major groups based on the distribution of the primary teaching responsibility. In one group the major responsibility for professional teaching resides with an academic unit (TRU #1). Such is the case with dental hygiene, medical technology, respiratory therapy, and radiologic technology where the faculty of the educational institution teach in the lecture, laboratory, and clinical settings. In the second group, the professional teaching is shared by a primary academic unit (TRU #1), composed of faculty at the educational institution, and a clinical preceptorship unit (TRU #2), made up of faculty who are practitioners in the clinical settings, *not* on the faculty of the educational institution in medical dietetics, medical records administration, physical therapy, and occupational therapy.

Sample cost constructions for these two group types are presented in Tables 1 and 2. Spaces are provided for the insertion of other options. For group one (Table 1), the primary department (TRU #1) values are presented in detail. For group two (Table 2), academic (TRU #1) and clinical (TRU #2) professional unit data are presented.

Changes in any of the variables listed on the tables and described in this chapter may cause the "bottom line" value to go up or down. Using the PCACM approach, the effects of changes in any or all of the variables can be evaluated. Consideration can be given to minimal number of students or faculty required to provide a cost-beneficial breakeven position.

Planning a Program: Identifying cost-beneficial options should also be combined with evaluation of existing and future sources of support, whether the support is in the form of direct financing (e.g., grants) or availability of resources (e.g., tuition) for program use. Having selected a cost-beneficial option for implementation it is important to consider the phasing of resource requirements, particularly for faculty and facilities. All costs do not exist on day one. Often start-up costs are mistaken for final operating costs. For continued support it is essential to identify at the start the costs that must be incurred at later dates, especially equipment replacements during the program maintenance stage.

TABLE 2: PCACM KEY VALUES CHART – GROUP TWO

**Allied Health Baccalaureate Program with Academic
and Clinical Primary Professional Units**

School	State University
Program	Allied Health
Degree Awarded	B.S.
Program Organization	4 years
Academic Session:	Semester
Length:	144 weeks
Student Contact Hours: Program Total	3,456
TRU No. 1 % of Total SCH	30%
TRU No. 2 % of Total SCH	25%
TRU No. 1 SCH % in:	50%
Lecture	50%
Laboratory	
Clinic	
Average SCH/Week	24
Student: Class Size	32
Faculty Contact Hours: Program Total	5,483
TRU No. 1 % of Total FCH	28%
TRU No. 2 % of Total FCH	51%
Average SCH/Student Output	171
Faculty Availability	
TRU No. 1 Full Time:	Hrs/Week 15
	Wks/Year 32
	Hours/Year 480
TRU No. 2 FTE:	Hrs/Week 38
	Wks/Year 48
	Hours/Year 1,824
FTE Faculty Required	
TRU No. 1 Full Time	3.2
TRU No. 2 FTE	1.5
Faculty Salary	
TRU No. 1 Full Time	\$25,000
TRU No. 2 FTE	\$27,000
Cost Factor:	
TRU No. 1 Faculty Cost % of Total Cost	48%
TRU No. 2 Faculty Cost % of Total Cost	30%
Average Cost per FCH:	
TRU No. 1:	Faculty Cost \$52
	Other Cost \$56
	Total Cost \$108
TRU No. 2:	Faculty Cost \$15
	Other Cost \$35
	Total Cost \$50
Average Cost per Student per Year	
TRU No. 1	\$1,300
TRU No. 2	\$1,054
Total Program	\$3,431
Average Cost Per Student Output	\$13,727
Attrition Rate	-
Average Cost per Graduate	\$13,727
% Above Cost/SO	

Source: CSHP: MAG: 5/7/82

SECTION IV. CONSORTIAL AND COOPERATIVE ARRANGEMENTS FOR ALLIED HEALTH

This section has been prepared in three parts and by three different writers in an attempt to provide a balanced and complete coverage of the very complex issue of consortial and cooperative arrangements for allied health between educational institutions, both private and public. The first sets forth the many points of consideration that will need to be addressed in interinstitutional agreements, especially from a legal standpoint. The second and third parts present specific considerations for agreements between minority institutions and for agreements between minority and majority institutions.

*A. General and Legal Consideration**

Introduction

Two prime factors lead academic institutions to consider cooperative and consortial arrangements for providing allied health education when otherwise they would not do so. Simply stated, those factors are *program availability* and *program expense*. With regard to the first of these points, *program availability*, clearly no institution in this country can offer academic opportunities in even many of the 150 or so allied health professions. In fact, it is probably true that no single state offers all allied health education programs among its various educational institutions. With regard to the second point, *program expense*, the typical academic institution engaged in allied health education usually has the potential for being cost-effective at the preprofessional level, but many find itself in a cost-prohibitive state at the professional or clinical level. Complicating matters is that conscientious academic institutions generally accept only that number of students into their professional programs that they can accommodate in participating clinical facilities. This often means that campus laboratories and academic faculty may not be utilized to fullest capacities, another cost increasing factor.

Given the importance of concerns about program availability and program expense, it may benefit academic institutions involved in educating allied health professionals to consider the benefits of cooperative and consortial instructional arrangements. By so doing, not only may greater numbers of programs be made available to an institution's students, but also cost benefits may make cooperation very worthwhile. A decision to pursue cooperative or consortial educational arrangements clearly involves careful consideration of many issues, some political. Political issues become more "real" in connection with arrangements between public and private institutions, either intrastate or interstate, or interstate between

* Prepared by Anderson J. Ward, Ph.D., J.D., Dean, College of Allied Health, Chicago State University.

public institutions. Further, different types of political issues arise when cooperative arrangements are between minority institutions and when they are between a minority and a majority institution. In order for cooperative or consortial arrangements to satisfy concerns about program availability and program expense, the political issues must be dealt with out front.

Academic institutions embarking on cooperative or consortial educational arrangements should be aware that a very complicated pathway lies ahead. Never is it a matter of just agreeing to provide collaborative educational processes, but among health professional educational efforts the situation becomes even more complex because of the necessity of satisfying the requirements of external professional accrediting agencies. Further, no matter how educationally attractive a cooperative arrangement might seem, if it presents insurmountable barriers to the prospective student, especially social or financial, its likelihood of succeeding is small. Therefore, institutions embarking on cooperative or consortial educational arrangements should pursue those arrangements from two different perspectives. First, institutions should carefully consider the interests, needs, and capabilities of their students. It may even be wise to include student representatives in the planning process. Second, institutions should carefully consider their own interests, needs, and desired outcomes, especially with regard to protecting legal interests and fairly assessing educational benefits versus cost. What follows are brief discussions of these points from both the student and institutional perspectives which may prove helpful to academic institutions considering cooperative or consortial arrangements for educating allied health professionals.

Student Perspectives

In reality, an institution's students are third party beneficiaries of any cooperative or consortial educational arrangement that an academic institution develops. However, students can be sharply compromised, perhaps even penalized, if the cooperating institutions do not agree on some very fundamental matters affecting students' existence. These can include matters such as tuitions, scholarships, loans, performance evaluations, the recommendation/selection processes and career awareness/recruitment responsibilities. It would be rare to locate any two institutions offering the same package of student benefits, providing the same level of student support, and charging identical tuitions and fees. Therefore, affiliating agreements between or among institutions must address these and similar points.

Fundamental among considerations of such concerns is the issue of who has control of the student. In a situation where institution "A" sends its students to institution "B" but collects the tuition itself, the students may still be under the theoretical, if not actual, control of "A". Under such a scenario, it may be that the students would function as if still on "A"'s campus, receiving all benefits and privileges flowing from that presumption, while "A" would merely pay "B" in a contractual manner for the educational services provided to its students. Similarly, "A"'s students might well receive financial packages from "A" as well as services such as academic counseling and career placement. "B", on the other hand, might provide, in addition to instructional services, such things as progress evaluations and future job recommendations. Any variation of this or other scenarios can be speculated upon. Common among them all, however, will be the fact that each involves certain expenses, benefits, workloads, and prestige to one or both institutions.

On another point, a major concern of students affected by cooperative or consortial arrangement always will be housing, especially if the college or university is some distance from available apartments or dormitories. A possible exception to that general proposition is where housing is furnished by the host institution. Private housing rentals generally are not available to students on a short-term basis. The expense of maintaining a second home arrangement for temporary intervals may be prohibitive. Therefore, cooperating institutions must address this issue early in negotiations. The greater the geographic distance between cooperating institutions and the shorter the period of time students physically are at the host site, the greater the level of difficulty for the student. In short, failure to provide suitable student housing arrangements may cause the demise of any cooperative effort developed, no matter how beneficial to the student on other fronts.

Cooperating institutions should also make note of the fact that the typical student population is becoming older, suggesting that today's students may have even less flexibility concerning such matters as housing. That is, they may not have parental financial support, they may necessarily be holding jobs, or they may be supporting families of their own.

Interinstitutional Considerations

Cooperating institutions must resolve various issues incidental to the cooperative process to assure the quality of academic training, to meet program accreditation standards, and to protect the interests of not only their institutions but also of their students. A typical, but by no means exhaustive, "laundry list" might include the following:

- Tuition payments;
- The degree;
- Clinical competency;
- Academic credit;
- Prerequisite requirements;
- Transfer;
- Record-keeping;
- Student slots;
- Program standards and requirements;
- Student performance, evaluations, and reports;
- Faculty appointments;
- Remuneration for services;
- Other contractual arrangements, informal and formal.

While this list is not meant to be exhaustive, it does underscore the intricacy of issues connected with academic cooperation. It is hoped that the following brief discussions of these items will point out the necessity for careful negotiation and consideration of cooperative strategies for allied health education.

Tuition Payments: An earlier scenario presented the issue of payments from the standpoint of "who" has control over the student. However, the tuition payments issues is far broader

than that. Fundamental is the fact that there is at least some relationship between tuition charged and program offerings. Predictably, among most private institutions the relationship of these two factors is far closer than among most publicly supported institutions. Tuition payments as a negotiable item, then, would appear more important in cooperative arrangements including one or more private institutional participants. Still, this issue can become very complicated even among public institutions. Consider the following scenario:

"A", a private institution offering only preprofessional allied health education to its students, has an agreement with "B", a public institution offering allied health clinical education through certain health care facilities affiliated with "B" for that purpose. "B", through a second set of affiliation agreements, must pay on a contractual basis its clinical affiliates for the training services that they provide. Obviously, any cooperative agreement negotiated between "A" and "B" might have to contain provisions for shifting tuition income from "A" to "B" so that "B", in turn, can pay its clinical affiliates.

Of course, if the student could pay tuition directly to "B", the matter might resolve itself. Experience indicates, though, that often students must maintain their home campus affiliation in order to receive support services available only to full-time students. In other words, a student taking some courses on his/her home campus and others on the host campus might be treated as a part-time student, thereby losing various benefits and privileges reserved to full-time students. Not the least of these benefits are student financial aid and work-study packages.

Additionally, the tuition payment issue takes on even more difficult aspects if one institution is publicly supported and the arrangement is interstate. The issue may arise as to whether the publicly supported institution, which by its very nature is subsidized through taxes of its state's citizens, can provide any educational service whatsoever to nonstate students without offsetting the taxpayer's subsidy, at least to some extent. If the public institution operates an out-of-state tuition program, then the matter is more easily resolved.

The Degree: In a cooperative arrangement between two institutions the matter of who awards the student his/her degree is reduced simply to two situations: (1) either one institution or the other recognizes transfer credit and awards the degree; or (2) the degree is jointly awarded. Consortial arrangements among three or more institutions become more complicated. Sometimes a jointly offered degree arrangement can be negotiated, but more often varying academic standards and institutional calendars make that possibility difficult.

Among those allied health professional associations requiring that individuals seeking professional registration hold an academic degree, many do not require that the degree be in the profession itself. For example, professional registration as a medical technologist requires that one possess an earned baccalaureate degree together with successful completion of an accredited medical technology education program that may be academically based or hospital based. A similar requirement exists for medical record administration and several other allied health professions.

This flexibility in acquiring the academic degree may not grant cooperating institutions much discretion in determining who actually offers the degree. Accordingly, it is feasible for a general academic institution to affiliate with a second academic institution offering clinical programs; the former institution accepting transfer credit for clinical programs and then offering the degree. An advantage to the second institution in such a consortial arrangement could be better utilization of professional level faculty and on-campus teaching clinics.

A second variation would be the general academic institution awarding academic credit for preprofessional studies which are then transferred and fully accepted by the professional level institution; the professional level institution eventually awards the degree. An advantage to the first institution under this situation could be increased enrollment and broader opportunities for its lower division student body. An advantage to the professional level institution could be the opportunity to select from a broader and presumably more diverse applicant group. A disadvantage of such an arrangement, however, could be that students would not be guaranteed clinical slots. Obviously, programs that do make such guarantees would be far more attractive to students.

Clinical Competency: It is safe to speculate that clinical competencies of students can be certified by only those partners in a cooperative educational arrangement who actually control and monitor students in clinical environments. Thus, the question of clinical competencies becomes more an issue of how they are translated into academic credits rather than actual certification skills.

Academic Credit: Some academic institutions offer block credit for clinical time. Most such arrangements usually involve programs requiring students to locate their own clinical training programs. A few, however, reflect affiliation agreements between academic institutions and clinical facilities. Other academic institutions transfer academic credits earned at the cooperating institution. This is most easily facilitated in cooperative arrangements where one partner offers clinical training, directly or indirectly. Lastly, there are those cooperative arrangements in which clinical training is achieved at the post-degree level, thus eliminating the necessity for academic credit transfer.

Transfer of nonclinical academic credit is usually handled by standard institutional procedures.

Prerequisite Requirements: Cooperating institutions generally concur that the host institution determines whether a prospective student has satisfactorily completed prerequisite requirements. There are two basic exceptions to this general rule. First, some cooperating institutions may establish a selection committee to determine satisfactory completion of prerequisites. Second, others may agree that a host institution will allocate a specific number of slots to qualified students. In these latter situations, qualifications may be established by the host institution, while determination of satisfactory completion of prerequisites may be made by the sponsoring institution. This arrangement helps assure that students receive fair consideration for admission.

Transfer: Most cooperative arrangements require students to enroll in the host institution where actual instructional services are being delivered. This may necessitate complete transfer to the host institution which, in turn, implies that matriculating students must fully satisfy that institution's admissions requirements. A second, perhaps more workable arrangement, is for the host institution to accept a sponsoring institution's students on a "special student" or "visiting student" basis. This second method permits matriculation in courses without necessarily satisfying totally the host institution's admission requirements. The attractiveness of this arrangement is that it encourages success of cooperative programs by not injecting unacceptable levels of general university distribution requirements, the time-consuming nature of which may discourage potential candidates. Third, some cooperating institutions may arrange instructional services for students at the host institution on a contractual basis. This method allows students to remain enrolled full-time at the sponsoring institution but take specific courses at the host institution, the cost being paid on a contractual basis between the institutions. In other words, the student continues to pay regular tuition to the sponsoring institution; the institutions settle accounts between themselves. This last arrangement often is very attractive from the student's standpoint, as it gives the best assurance for continued financial assistance and other services often unavailable to part-time students.

Record-keeping: Most often institutions actually delivering instructional services maintain original academic records for students. Cooperative arrangements, then, simply must determine in advance how these records are to be transferred between institutions. Clearly, students must agree in writing to the sharing of such information between the institutions so that neither institution violates the student's rights under the Privacy Act.

Student Slots: In general, host institutions are reluctant to allocate specific slots to sponsoring institutions. The arguments proffered are many. Some institutions claim that by allocating slots, their ability to recruit the most highly qualified students may be compromised. A second major argument is that the host institution cannot risk doing for one what it may not be able to do for all. An opposing argument is, of course, that cooperative arrangements are often meaningless unless student access is guaranteed.

Ideally, cooperative institutions will deal with this issue early. One way to satisfy the intent of guaranteed student slots may be the inclusion of representatives from the sponsoring institution on the host institution's selection committee. This at least creates an advocacy opportunity for the sponsoring partner. An alternative is an agreement to make student slots provisionally available to the sponsoring partner. For example, a sponsoring partner may enter an agreement with "X" number of student slots allocated; the number of slots subject to renegotiation at established intervals on the basis of various "feedback" data. Some examples of "feedback" data could be student performance on national registry examination, percentage of student dropouts, and comparative scholastic performance.

Program Standards and Requirements: The host institution, especially if it offers clinical training, is the proper party to determine program standards and requirements. Cooperative arrangements may allow interinstitutional representation on various academic standards committees, but the ultimate responsibility lies with the program itself. Accordingly, co-

operating partners often must accept externally imposed regulations in order to have the agreement move forward. This is particularly true among programs externally accredited by allied health professional associations. As a general rule, accrediting agencies do require formalized agreements in order for cooperating institutions to offer training under one institution's accreditation authority.

Student Performance, Evaluations, and Reports: Again, the responsibility for judging student performance, evaluating that performance and documenting it through various report mechanisms lies with the host institution actually providing instructional services. To avoid misunderstandings in this area, it perhaps is wise for cooperating institutions to establish inter-institutional overview committees to monitor these mechanisms. One of the most destructive forces to cooperative arrangements can be the disgruntled student claiming unfair treatment, discrimination, or general social unacceptance. Problems of this type can be minimized, if not eliminated, by establishing some sort of overview control.

Faculty Appointments: There are three basic mechanisms for handling faculty appointments among cooperating institutions. First, the faculty simply maintain academic appointments at the employing institution with no official connection with the cooperating institution. Second, some institutions arrange courtesy adjunct appointments for programmatic faculty of cooperating institutions. This latter mechanism may be attractive from the standpoint of encouraging greater cooperation on the part of all faculty members, and may help underscore the various cooperative roles of all parties. Third, there may be the situation where cooperating institutions arrange full faculty appointments for the other institution's faculty. These arrangements, which require fiscal commitments, are most often found in clinical instruction settings. A fourth, less common, arrangement is the cooperating partner's contractually remunerating the host institution for the personal services of its employee. This amounts to a release-time arrangement not necessarily involving reciprocal academic appointments.

Remuneration for Services: As discussed above, remuneration for services may be handled through contractual mechanisms, thereby minimizing problems connected with employment of personnel. In other words, the least complicated arrangements usually provide for lump sum payments as opposed to complicated contingent formulas for determining remuneration amounts.

Other Contractual Arrangements, Informal and Formal: The many items relevant to cooperative and consortial arrangements that have been mentioned are major items to be negotiated and settled. However, the list is by no means exhaustive. The likelihood is that most cooperative and consortial arrangements will include a wide variety of other agreements. These other agreements, formal or informal, may speak to the educational aspects of the venture as well as such things as grievance rights and procedures, student affairs, nonmonetary benefits to faculty and major institutional assurances such as nondiscriminatory selection of students and continuation of programmatic accreditation standards. Along these lines, it is surely best to enumerate and thoroughly detail each relevant item, rather than risk the possibility of some minor misunderstanding damaging the total cooperative effort.

*B. Cooperative Relationships Among Minority Institutions
For Allied Health Education**

Background and Need

As stated previously in this publication, programs for the preparation of allied health professionals are far less prevalent in minority colleges and universities (an average of one program per AASCU institution) than in majority institutions (an average of 2.8 programs per AASCU institution). Admission to allied health programs at any institution is usually competitive, further restricting their access to minority students. The potential for implementing an array of allied health programs to meet all of the needs and interests of minority students at any single minority institution is slim. Yet students who attend minority institutions do so because the institution meets their needs for socialization and scholarly growth in an environment designed specifically for them. To meet the increasing need for minority allied health professionals, it is essential that mechanisms be developed to allow students interested in the various allied health careers to pursue those curricula while attending minority institutions.

To meet the needs of students for greater accessibility to allied health programs in minority institutions, five historically Black institutions in the southeastern United States have joined together in an interinstitutional partnership. By working together, these institutions hope to increase the pool of qualified applicants to the allied health programs currently in existence and implement new programs to provide a greater variety of allied health career options.

Objectives

Cooperative relationships among minority institutions should serve the students of those institutions, the faculty, and the institution as a whole. The specific objectives of cooperative relationships in allied health education are to:

- Provide a formal mechanism to allow students a variety of allied health career options within a minority institutional setting;
- Allow students who take portions of their curriculum at two different participating minority institutions to qualify for degrees from both institutions, i.e., joint degrees;
- Identify and counsel qualified and capable students who are interested in an allied health career early in their college program;
- Provide allied health career awareness opportunities/activities on the campuses of each participating institution for the benefit of students and for faculty who will be counseling the students;
- Upgrade the quality and quantity of the applicant pool for allied health professional curricula at participating institutions;

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- Strengthen the preprofessional curricula at participating institutions (e.g., availability, relevance, depth);
- Make the movement of students between institutions as uncomplicated and barrier-free as possible;
- Increase substantive communication on allied health education among and between participating institutions.

Methods

There are many activities that can be implemented to meet the objectives specified above. The intent here is to suggest a few of those activities with a rationale for each. Institutions that consider cooperative relationships in allied health education will certainly expand or modify these suggestions to meet their own needs.

Designation of a Campus Coordinator: One person from each participating institution should be designated as the campus coordinator for the cooperative relationship. It is preferable that this individual have official administrative status (or actually be an administrator) at the institution. Ideally this person should be explicitly charged with the responsibility for developing and maintaining the cooperative relationship, have the authority to make administrative decisions relative to the project, and be given release-time to carry out the project activities. Of course, some decisions will require input and approval from other institutional personnel (i.e., administrators and faculty), but the interinstitutional frustrations and delays caused by denying coordinators basic operational decision making authority can destroy the cooperative project.

The role of the coordinator would entail (1) working out the structure of interinstitutional agreements for approval by the appropriate institutional bodies (i.e., boards of trustees, administration, faculty committees); (2) developing mechanisms for the transfer of credits, evaluation of applicants, maintenance of necessary records, and interinstitutional communication; (3) acting as the bridge between the project and faculty involved with students moving among institutions; (4) planning, with coordinators from other participating institutions, appropriate seminars, workshops, and minicourses for faculty and students participating in the project; (5) preparing materials to publicize the project; (6) planning recruitment and career awareness activities; (7) developing procedures for identifying students who are capable and interested in pursuing an allied health program; and (8) acting as a liaison between the project and the institutional faculty to modify and enhance preprofessional curricula (if necessary) to facilitate student entrance into the professional phase of the allied health programs.

Offer Interinstitutional Seminars/Workshops: In order for the project to be successful, it is imperative that faculty and student advisors be properly oriented and have the opportunity for interchange of ideas, concerns, and plans. Non-allied health faculty and advisors need to be oriented to the professions represented in the participating institutions so that they can assist students to prepare for these careers. If possible, faculty exchange programs among institutions should be encouraged.

Interinstitutional seminars and workshops for students are highly recommended as important motivational information experiences. If possible, students should visit the campus that has the program of their choice to become acquainted with the faculty and the facilities. The importance of early acquaintance with the faculty cannot be overemphasized.

Develop Preceptors/Mentors/Role Models: One of the obvious problems associated with the underrepresentation of minorities in the allied health professions is the dearth of minority role models. In order to motivate students and to provide them with the opportunities to make informed decisions about career goals, a concerted effort must be undertaken to identify and enlist the cooperation of minority allied health professionals. These professionals can take interested students into the workplace for first-hand observations of the actual professional responsibilities. They can also provide the guidance necessary to assimilate those observations into educational and career plans. Mentor relationships cannot be forced upon either students or allied health professionals, but a by-product of these associations may be continued communication and guidance.

Publicize and Disseminate Information about Allied Health Careers: Information relative to allied health careers, financial aid, and the cooperative relationship option should be published and disseminated widely. High school students may actually choose one of the colleges or universities among the participating institutions because of the availability of the allied health programs, thereby increasing overall enrollment. Information on the allied health career options may motivate and retain students already enrolled at the institution who might otherwise drop out.

Sponsor Career Day Activities and Health Fairs: These activities require participation by the health care community. Through such participation, the practitioners in the community become acquainted with the people and programs of the college. The potential for further joint activities and liaisons is endless.

Substantively, these career-oriented activities provide a mechanism for students to begin their awareness of health careers. Follow-up on student interest is an important component, if the recruitment potential of these activities is to be fully realized.

Offer Summer Enrichment Programs: Often campuses are nearly deserted in the summer months. The use of this time and the facilities of the campus for programs that reinforce skills (e.g., mathematics, science, communications) and provide an orientation to the professional curricula is the one most successful activity for the retention of allied health students. The shock of transition from preprofessional studies to an intense professional curriculum is mollified. If a change of institutional setting is necessary, that transition is also aided by summer enrichment programs. The students' self-confidence is greatly enhanced when the regular school year begins and they feel they are somewhat "ahead of the game."

The methods of achieving the project objectives presented above are only a few of many possibilities. As cooperating institutions plan together, new and unique activities will result. Any program should be flexible enough to meet student and institutional needs.

Evaluation

Periodic reviews of the cooperative project are necessary to assess the degree to which the objectives are being met. Projects such as this one can sometimes become self-serving if they are not evaluated in light of their objectives. The overall goal of the interinstitutional relationship is to increase the accessibility and quality of allied health programs for students who are minorities. That goal should guide all activities.

The project review should contain student evaluations, course evaluations, data relative to the numbers of students choosing careers in allied health prior to and during the project, follow-up studies, faculty and preceptor evaluations of the project's procedures and objectives, and data on the impact of career days and other project activities. A report of the findings of the reviews should be submitted to the administrations of each participating institution so that decisions on the continuation and revision of the project can be made using all pertinent information.

C. Cooperative Relationships Between Minority and Majority Institutions

Background and Need

As was stated in the previous (minority/minority) section, allied health programs in minority institutions have been relatively rare. While the new programs developed during the conduct of this project will give minority students greater numbers of options in minority settings in a number of states, most allied health programs are offered in majority institutions. Collaboration for allied health education within a given geographic area, then, often will need to be with a majority institution, generally a university health science center offering an array of medical, dental, and allied health programs. Even for minority institutions that themselves offer some allied health programs, collaboration with majority institutions can be helpful in giving students more options of program types, as will be discussed.

Many, if not most, of the large university medical centers in the southern states visited during the project have poor records of minority student recruitment/admissions/retention efforts in their allied health programs. Despite often being rather large (30-60 students), most allied health programs in Southern medical centers had no minority students at all, a few had one or two, or in rare cases, five or six. With only a few notable exceptions (e.g., University of Texas Health Science Center at Galveston and the University of Alabama at Birmingham), most allied health program personnel were making little effort to recruit minority students. Several of the program directors expressed open resistance to the idea of active recruitment of minorities, fearing that program selection standards would need to be lowered. Further, only a few programs had even one minority faculty member. Not surprisingly, the few minority students who were admitted to allied health programs in majority institutions often did not complete the program.

Surprisingly few viable minority/majority institutional cooperative arrangements for allied health exist, and many of those that do exist simply involve (and usually not very success-

fully) minority students being accepted and transferring to the professional component of an allied health program at a majority institution—with little or no dialogue and usually no contractual agreement between the institutions. During the course of the project, then, we had few models of majority/minority institutional cooperation to use. Rather, we queried numerous sources within both minority and majority settings to attempt to determine the difficulties, problems, attempted solutions, and opinions of concerned and involved individuals with regard to minority students from minority institutions being placed in majority institutional allied health programs. The recommendations that the staff made during the project and also made in this section resulted from numerous staff discussions about the information received from the many sources. In fairness, it should be emphasized that while we believe that cooperation between minority and majority institutions can be successful if the cautions presented here are fully considered—we do not know for certain, since it is too early to assess any such arrangements that have been established during the course of the project.

The basic presumption of this (minority/majority) section is that the majority institution will offer the allied health programs and that the collaboration will result in providing access to those programs for minority students from minority institutions. (The reverse of this situation, majority students seeking access to allied health programs in minority institutions, did not arise as an issue during the conduct of the project, and will not be addressed here).

Objectives

Cooperative arrangements between minority and majority institutions should serve to:

- Provide a greater number of allied health career options for students enrolled in the minority institution;
- Provide greater access to allied health programs in majority institutions for minority students than otherwise would be the case;
- Provide support for students from minority institutions enrolled in allied health programs in majority institutions.

Methods

The specifics of any cooperative arrangement between a minority and a majority institution will vary, but generally the following areas will need to be addressed and included in the contractual arrangements between the institutions.

Designation of an Allied Health Coordinator: A campus-based individual needs to be appointed to assume responsibility as the allied health coordinator, as has been described in the previous presentation (minority/minority relationships).

Preclinical Courses: The mathematics, science, and other courses that are required for student admission to the professional component of an allied health program are established

by the program faculty and must be in compliance with the accreditation essentials (standards). This preclinical or preprofessional portion of the allied health curriculum usually requires four or five semesters (freshman and sophomore years); it should include the specific course requirements of the program, the general graduation requirements of one or both cooperating institutions, and introductory courses in the health care system and the allied health profession for which the student is preparing. (See the "Preclinical Curriculum" portion of Section III *New Programs* of this document for further information.

It is crucial that students coming from minority institutions be competitive with those from other institutions, both in terms of meeting selection criteria for admission to the allied health program, and in terms of the quality and type of preclinical courses taken. Generally, it is best to begin by supplying the host (i.e., majority) institution's program directors with a college catalog listing courses, as well as course outlines of those offerings that appear to be appropriate for the preprofessional curriculum. Modifications in the course content and/or prerequisites may need to be made upon the advice of the program director.

In some instances one or more courses are required in the preprofessional curriculum that are not offered by the minority institution. When this problem occurs, it will be incumbent upon *both* the majority and the minority institutions to determine a way of resolving the deficiency. Students, for example, may be required to attend a special summer session at the host institution, or the host institution may send its faculty members to the minority institution to teach the required course(s).

If large numbers of students are expected to enroll in the preprofessional curricula, the impact of those students on specific course enrollments should also be anticipated. Further, any new or modified courses that are offered for allied health students will need to be accepted by the traditional academic departments as counting toward a major in the field of study in which it is offered (this is necessary for those students who do not go into the professional portion of the program, but remain at the minority institution and seek a non-allied health major).

During the preprofessional portion of the curriculum it will be important to provide students with opportunities to visit clinical practice sites and the clinical training facilities of the host institution in order for them to get a clear understanding of the profession for which they are preparing. Arrangements for such experiences should be made and scheduled by the beginning of each academic year; program faculty should suggest sites and be present during the visits.

It will be extremely helpful if joint faculty appointments in the minority and majority institutions can be made for faculty who have teaching and/or administrative responsibilities on both campuses. These appointments may or may not include payment from both institutions.

Career Awareness/Recruitment Activities: Career awareness and recruitment activities for potential allied health students will need to be geared toward those already enrolled in the institution as well as potential enrollees. Specific strategies for these activities are included

in Section VI. While the strategies themselves are pertinent for the recruitment of students in either new programs or cooperative programs, for cooperative programs the minority institution will need to work with the host institution in the development and implementation of the strategies.

Student Selection to the Allied Health Programs: As has been indicated previously in this publication, selection to the professional portion of allied health programs usually takes place during the students' sophomore year with actual entry into the program occurring in the summer or fall of the junior year. The selection process includes an evaluation of courses taken, grade point average (GPA), faculty recommendations, and often an interview. In many allied health programs in majority institutions the competition for selection is keen, with many more applications than student places in the program. Grade point average requirements of 3.2 or higher are not uncommon for selection to some types of programs.

Major stumbling blocks to the admitting of minority students to allied health programs in majority institutions have included students' perceived lack of academic preparation, particularly in the sciences, insufficiently high GPA's and perceived poor performances in interview situations. Each of these hindrances needs to be addressed in the development of cooperative arrangements between a minority and a majority institution. Academic preparation adequacy should be assured through ongoing evaluations of the preclinical curriculum by both the minority and the majority institution. If areas of inadequate student preparation become evident as a result of those evaluations, steps will need to be taken to remedy this situation.

It will be crucial that the minority students who are recommended for and apply to allied health programs in the cooperating institution be academically strong, and be sufficiently mature and committed to withstand the rigors of the clinical phase of the allied health program. While a student's GPA is important, the other factors vital to success are not always reflected in transcripts. Since those factors are best evaluated by the minority institution, it is important that the minority institution maintain the control over which students are recommended and/or granted guaranteed student places, when they exist. As will be discussed, guaranteed places are important to the success of any cooperative arrangements between minority and majority institutions.

The third area of potential hindrance to the minority student in his or her selection to an allied health program in a majority institution, i.e., poor performance in the interview process, needs to be anticipated and prevented to the greatest extent possible through joint efforts of the minority and majority institutions. Mock interviews conducted for students by one or two members of the selection committee from the majority institution well before the actual interviews are helpful for both students and interviewers. Students should also be strongly encouraged to treat these mock, as well as actual, interviews as though they were interviews for professional employment. It is also important that the majority institution have at least one minority member on the selection committee of each allied health program. While this would seem both obvious and simple, given the complete absence of minority faculty members in many of the programs, it can present a problem. Area minority allied health practitioners or physicians or faculty members from the minority institution can be

made voting members of the selection committee if no minority allied health faculty are available.

Guaranteed Student Places and Student Support Systems: Guaranteeing the minority institution several student places in each of the allied health programs offered by the cooperating majority institution is often controversial among the allied health faculty. It is, however, important to the success of both minority students and the minority institution, if certain guidelines are established, as follows:

- There should be no fewer than three-four guaranteed slots for minority students per program, although not all slots need to be given to any one institution; this number creates a "critical mass" of minority students who can provide peer support;
- Minority students who are accepted into guaranteed slots must have at least the minimum GPA required by the program for admission, and preferably higher;
- As indicated in the previous section, the minority institution needs to retain the right of recommendation of students for the guaranteed slots. The selection committee, too, should include at least one minority member;
- Guaranteed slots should not preclude applications from other students from the minority institution to the programs.

Support systems for students once they are enrolled in allied health programs at the majority institution are crucial. Inadequate or nonexistent support systems appear to be at least one of the most important reasons for minority students dropping out during the professional portion of the curriculum; this is especially true for Hispanic and Native American students. Particularly for students from rural areas accepted into allied health programs in majority institutions in large metropolitan areas, considerable culture shock can occur.

(There are various ways of handling the stress that such a cultural change can create for students, although none appear to be wholly effective. The University of Alaska at Fairbanks, for example, provides a special student center and considerable counseling support for its Native Alaskan students; Pan American University is working with the University of Texas Health Science Centers at Dallas and Galveston to provide housing and support for Hispanic allied health students within the Hispanic communities of those cities.)

It would also appear that the continued direct involvement of the minority institution with the student once he or she is enrolled in the majority institution is important in assisting the student to adapt to the new environment. Examples of such involvement include scheduling students to talk to preprofessional students on the minority campus, and scheduling regular (monthly, if possible) meetings with students and the allied health coordinator. If the minority school has at least several allied health students enrolled on the majority campus, the majority institution should provide an office and limited faculty privileges (e.g., parking, library use) to the allied health coordinator from the minority institution. If an office is provided, it can also double as a place for minority students to meet with each other. A basic point here is that the majority institution needs to provide the allied health coordinator with easy access to students from the minority institution. Further, the allied

health coordinator should have access to allied health program directors and faculty and have the right to act as liaison between the student and the program director in the case of grievances. If there is no office of minority affairs for health science students at the majority institution and/or no minority faculty members in the allied health program, the role of liaison becomes particularly crucial.

Joint Degrees: It is generally desirable that a student, upon completion of the allied health program at the majority institution, be granted a baccalaureate degree from each of the co-operating institutions. Joint degrees often mean rather complicated record-keeping and formal acceptance of transfer credits on the part of each institution. However, we believe the resulting benefits to the students and participating institutions outweigh the costs.

SECTION V. ALLIED HEALTH PROGRAM IMPROVEMENT*

A. Introduction

The allied health professions are, by nature, dynamic and changing fields that are extremely sensitive to technological change and legislative actions. Educational programs in allied health must be flexible to accommodate these changes. Faculty and administrators share in the responsibility for assuring that the educational experiences necessary to prepare competent allied health practitioners are up-to-date and adequately supported. Program improvement, then, is a continuous process and should not be construed as an activity to be undertaken only when a serious problem arises. While problems do surface occasionally requiring immediate and decisive action, generally such "crisis management" can be avoided if a process of ongoing evaluation and communication is carried out.

Identification of Needs for Improvement

The first step in identifying needs for improvement is creating a recognition among faculty and administrators that problems can and will exist. Unfortunately, it is common to ignore small problems until they loom large enough to be a serious detriment to the quality of student preparation. For example, the practice of deferred maintenance of facilities and equipment, undertaken by many institutions of higher education during difficult financial times, has severely hampered their ability to provide the necessary instruction in many educational programs. Ignoring problems such as this one may eventually lead to elimination of some programs altogether.

Responsibility for Problem Identification

Problems (needs for improvement) associated with allied health programs may be identified by several groups: students, faculty, program administration, clinical supervisors, and accrediting agencies. The first important step in program improvement is communication among these groups so that problems are acknowledged and a plan of action developed to address the problems. Failure to address what may be small problems that can be solved rather easily may result in their being compounded by neglect and surfacing later as more serious concerns. (Students and program faculty, for example, may view evening scheduling of student training at a particular clinical facility as a "problem," while the program director and clinical supervisor, who worked out the agreement for the schedule, know that the hours are necessitated by heavy daytime use of the facility by other student groups.)

As problems are identified and acknowledged, some resolution should occur; either a solution found or planned and supported, or formal documentation of the problem made and shared

* Prepared by Mary Lee Siebert, Ed.D.

with administrators or others in the educational hierarchy who must share the responsibility for a solution, i.e., chairpersons, deans, chief executive officers. A situation such as the chief executive officer of an institution being surprised by a letter from an allied health accrediting agency stating that the program has been put on probation or that the program has lost its accreditation entirely should be avoided.

Common Trouble Spots in Allied Health Programs

If routine communication between the allied health program director(s) and the central administration does not occur and/or if the communication is not definitive (e.g., vague, global), the central administration should request a report at least annually from the program director(s).

Questions that require the following information are likely to identify trouble spots, if there are any:

- Class capacity vs. actual enrollment: Recruitment, applicant pool, and admission problems may be found;
- Availability of clinical affiliates vs. actual clinical sites needed: These data may point to potential problems in student placement requiring adjustment in class capacity/enrollment;
- Numbers of students taking certification exams the first time vs. the numbers passing the first time: If the number of graduates failing the exam the first time exceeds 15 percent there is a *serious problem* requiring immediate solutions. If this situation persists, external (accrediting) agencies usually become quickly aware of it and may request an early accreditation site-visit;
- Number of graduates admitted to the program vs. the number who graduated: Attrition rates of over 30 percent are cause for serious concern. The reasons for high attrition are usually linked to a problem of admitting students who are not academically prepared to be successful in the program. Remediation activities should take place *prior* to student admission into an allied health program, not during the professional curriculum;
- Institutional ability to teach basic clinical skills: Student laboratory facilities available at the institution should be sufficient to teach all or nearly all of the basic professional skills needed by students. The more students must go to clinical facilities to learn basic skills, the less adequate the institutional facilities can be considered to be;
- Employability of graduates: If 15 percent or more of program graduates are unable to secure employment for which their degree qualifies them within two or three months after graduation, there may be a problem. Currently jobs for graduates in the allied health professions are plentiful in most locales; lack of employment of graduates may be due to a reputation of poor quality graduates coming from the program or to a saturation of the market for a particular allied health professional in a given geographic area;
- Curriculum updating: What has been done to update the curriculum during the past several years? Rarely does an allied health curriculum not need some revision and updating each year. All of the program faculty should be involved in this process;
- Faculty development: Faculty members should have engaged in some activity designed to keep them current in their fields or in teaching. Continuing education or research

activities do not all require expensive travel and tuition, and faculty must assume some responsibility for their own professional development;

- Communication with accrediting agency: Copies of all communications from and to the accrediting agency should be requested from the program director since not all communications are copied routinely to the general institutional administration. Review of these documents is essential to an awareness of problems identified by the agency, and to an assessment of what is being done to address them by the faculty.

Finally, there is simply no substitute for a visit by academic administrators and/or chief executive officers to the program's facilities when students are present. An unannounced "walk through" and a few minutes taken to talk with faculty and students at their work will often result in an awareness of the ambience of the program that no report will express.

B. Common Programmatic Problems in Minority Institutions

As a result of the AASCU Minority Allied Health Project, several problem areas in allied health education in minority institutions have been identified. These problem areas are by no means unique to minority institutions, but they seem to be more prevalent in those settings.

- Student qualifications and recruitment: In general, the academic qualifications of the applicant pool in allied health are marginal for success in the rigors of the professional allied health curricula. One reason for this situation appears to be a serious lack of career awareness in the allied health professions among minority students and their advisors. The academically strong students interested in health careers are actively encouraged into medicine, dentistry, and nursing, but little is being done to stimulate interest in the other health career options. Even when students are not admitted to schools of medicine, dentistry, or nursing, there appears to be little encouragement for them to consider allied health options;
- Faculty qualifications and recruitment: The identification and recruitment of qualified allied health faculty and program directors is a serious national problem, but is much more severe in minority institutions. Allied health faculty who are themselves minorities are extremely rare, and national searches for faculty through the usual media are only minimally successful;
- Clinical sites and personnel: Good clinical affiliations are difficult to obtain. There is often great competition in urban centers for a few sites. However, one of the biggest problems identified during the Project was the reluctance of personnel from minority institutions to aggressively explore all potential avenues for such affiliations. Barriers do still exist for minority institutions; to ignore that fact would be naive. On the other hand, health care agencies that can provide clinical affiliations are more open to such affiliations with minority institutions than they once were. Some "replowing" of old ground often results in success. The rural or semirural locations of many minority institutions is still a serious deterrent to finding appropriate affiliation sites. Local health care facilities that would like to provide affiliations for students simply may not be suit-

able. Use of such facilities, while meeting the requirements for time in clinical experience by students, may not meet curricular or accreditation requirements for depth and variety of experiences. Careful monitoring of this situation is essential to continued compliance with accreditation standards.

- **Record-keeping:** Systematic, comprehensive, and complete record-keeping is critical to maintenance of accreditation. As far as accreditation survey teams are concerned, missing or incomplete records mean that essential components of the educational process are not happening. Some accrediting agencies stipulate that compliance with the essentials requires that a program have full-time clerical/secretarial support. All too often financial constraints result in cutting this service. Commonly, missing or incomplete records are the consequence. How much clerical support is "adequate" may vary, but a good rule of thumb to start with as minimal is at least one full-time clerical support person to eight faculty or to two programs (even if fewer than eight faculty);
- **Requests for assistance:** It appears that minority institutions are sometimes more reluctant to request assistance for their allied health efforts from accrediting agencies and independent consultants than are majority institutions. One result of this reluctance is that problems may not be either acknowledged or resolved. A common concern of program administrators and faculty is that there are only a few consultants who are minorities themselves and thus would understand what they are trying to do. Throughout the Project many consultants, both minorities and non-minorities, have been sensitive to the mission of the institutions while providing invaluable assistance to programs. The quality of the program and its compliance with the essentials of accreditation need to be the highest priority criteria used in assessing program needs, not the nature of the institutional mission;
- **Fiscal constraints:** Allied health programs in minority institutions face more serious financial problems than those in majority institutions because their institutions in general have more serious financial concerns. Faculty are expensive, usually requiring higher salaries than other faculty in the institution who have higher level academic preparation and more experience in higher education. Equipment and facilities for essential single-purpose laboratories are expensive. Enrollments in allied health programs are small compared to other majors in the institution, and faculty/student ratios are high. All of these things lead to the conclusion that institutional commitment to allied health education must be strong, or the programs will not survive. Although there may be "pockets" of grant money available if sought rigorously, the days of federal support for allied health start-up and operational costs are gone. An institution should be willing to assume the operation of allied health programs with institutional funds, otherwise the programs should not be implemented.

C. Problem Solving/Program Improvement

As problems are identified and plans developed for solving them, it is often helpful to have the consultation of an expert in the field from outside the institution. Good consultants are well worth their expense. An institution can find appropriate consultants by contacting the appropriate allied health professional association and/or accrediting agency for a list of

individuals who are recommended for their experience and expertise (also, see Appendix F for recommended consultants). To assure that a consultant's expertise is suitable, it is wise to get references from the person before making a commitment. It is also important that, when communicating with a potential consultant, the specific expectations of the consultation are spelled out, i.e., timetable, objectives of the consultation, report contents, expected delivery date, travel and lodging arrangements, and remuneration. Although a consultant is hired for particular programs, institutional administrators should meet with the consultant to discuss program issues and consultant observations. A copy of the consultant's report should be sent to the chief executive officer as well as to the program administrator.

Hiring a consultant is not a solution to a problem. It is after the consultant leaves and things are back to "business as usual" that solutions must be implemented. It is very important that institutional administrators follow up after consultant visits to ensure that program administrators have a feasible plan for implementing solutions. Periodic written reports on progress, shared with institutional administrators, can be very helpful in maintaining communication.

There may be instances when consultants have not understood fully the needs and expectations of the institution. Therefore, the reports may not contain reasonable/feasible options for solutions to problems. In cases where the problems for which the consultant was brought in were identified by the accrediting agency, it may be helpful to share the consultant's recommendations with the accrediting agency to determine the appropriateness of the options presented for resolution of the problem.

SECTION VI. ALLIED HEALTH CAREER AWARENESS/STUDENT RECRUITMENT AND RETENTION*

A. Introduction

- An often underrecognized but vital aspect of successful allied health program implementation is the recruitment of sufficient numbers of qualified students to the programs. While allied health programs in majority colleges and universities usually have many more student applicants than can be accommodated, this is not always the case in minority institutions. Many factors affect the minority student's ability to make informed decisions about an allied health career, including:
 - Lack of information and knowledge about the range of career options, job opportunities, and earning potential of careers in allied health;
 - Scarcity of minority role models in allied health professions who can provide students with motivation and information;
 - Inadequate academic preparation that is often the result of guidance counseling that discourages them from taking science and mathematics courses and encourages them to pursue less "demanding" course work and careers;
 - Limited access to the health care environment in the formative period of career decision making;
 - Greater attractiveness of other professions that have greater public visibility than allied health and that actively recruit the more capable minority students.

These factors have not only had a negative impact on minority students, but also on minority colleges and universities that offer allied health education programs. The effect is often small and poorly prepared minority applicant pools for allied health programs, as well as low retention rates. A comprehensive approach to allied health career awareness, recruitment, and retention can reduce these negative factors.

A variety of strategies can be devised to attract and retain students in allied health programs; a number of such strategies will be presented here. Clearly the strategy will need to be tailored to fit the target audience and its information needs. Further, meticulous record-keeping of students, their interests, and follow-up activities will need to be maintained.

* "Allied Health Career Awareness/Student Recruitment and Retention" contributed by Sharon McConnell, M.S., Instructional Technologist, Extended Learning Institute, Northern Virginia Community College.

While minority institutions have been clearly successful in attracting minority students in general, recruitment specifically for allied health programs has been varyingly successful in the institutions. Moreover, the geographic areas in which special allied health recruitment efforts are undertaken can pose a dilemma, especially for private minority colleges and universities with a broad-based potential student constituency. Most institutions employ two levels of effort in allied health recruitment: regional and nonregional. Regional efforts can be considered to be those within the state or within a radius that includes several states. Allied health recruitment efforts within the region can employ strategies that involve allied health faculty and students as well as recruitment office personnel. Such recruitment efforts outside of the region will generally need to be tied in directly with regular institutional recruitment activities and usually do not involve allied health personnel.

An additional dilemma for institutions is the degree to which they try to inform students about the whole spectrum of allied health careers versus only those offered by the institution. While limited institutional resources may preclude in-depth career awareness presentation of all or even most of the allied health fields, the degree to which it can be done can only benefit minority students in the long run. If at all possible, such presentations should include listings of programs at other educational institutions for allied health fields not offered by the institution itself.

An overview, then, of strategies for allied health career awareness/student recruitment and retention are as follows:

- Identify a variety of minority student audiences;
- Increase their knowledge of and interest in the allied health professions;
- Provide minority students with information on curriculum planning, academic preparation and process, and financial aid;
- Direct them to support services that will help assure their chances of successful completion of an allied health education program.

The objectives of the strategy form the basis on which to evaluate its effectiveness in attracting students. Good record-keeping and follow-up data collection are essential, including the number of students who participated, the number of participants who requested additional information, and the number of participants who went on to apply to an allied health science program.

Determining Information Needs

The next step in the planning process is to determine what information the target audiences need. An assessment of the audience's level of knowledge of allied health careers and academic preparation must be made in order to design a strategy that is both informative and interesting. A recruitment strategy designed for secondary school students would probably not include all the information that an audience of undergraduate transfer students would need or want, for example. It is generally safe to assume that offering a broad range of

general information about allied health careers and pre-professional preparation will be of value to any target audience, but do not fail to include the auxiliary information needs of special audiences.

An equally important decision is the determination of which allied health programs and careers to inform audiences about. Should information be limited to the university's allied health programs or should it include region-wide information on allied health education programs and the full range of allied health careers? Although the issue is debatable, the general consensus among allied health educators is that information on a broad range of educational programs representing a variety of careers should be offered. Regional cooperation between schools of allied health in sharing information and resources can be beneficial in matching the varied skills and career goals of qualified students with programs that will meet their needs.

Selecting a Strategy

Once the audience has been identified and the type and scope of its information needs determined the most effective strategies to inform and recruit these students can be identified and planned. Any number of career awareness and recruitment strategies can be developed to address the same problems. Although a strategy developed in one situation may be quite effective in accomplishing its objectives, the same strategy without modifications may not be as successful in a different setting. It is therefore advisable to examine any model strategy with a thought to how it can be "tailored" to accommodate the characteristics and needs of the particular audiences and the circumstances of the community, college, and setting in which the strategy will be presented.

Evaluating Effectiveness

To determine the effectiveness of a strategy, two aspects must be examined: the apparent efficiency of the strategy and its impact on attracting qualified minority students to allied health programs. One immediate way to assess a strategy's effectiveness is to "debrief" strategy workers and sponsors, as well as student participants who can be asked for their subjective opinions of the methods used.

The objectives of the strategy, set out, form the basis on which to evaluate its effectiveness in attracting students. Good record-keeping and follow-up data collection are essential, including the number of students who participated, the number of participants who requested additional information, and the number of participants who went on to apply to an allied health science program. A determination of the amount of information students retain from participation in various career education and recruitment strategies can be assessed through post-activity questionnaires or personal interviews.

General Strategies that Increase Effectiveness

Trial and error have yielded some general aspects of career awareness and recruitment strategies that appear to work, including:

- Participation of minority role clinicians, students, and faculty;
- Parental and family involvement;
- Scheduling that allows the greatest chances for target student participation;
- Diligent record-keeping of student participants and an effective system of tracking student progress;
- Community and college-wide involvement and visibility;
- Opportunities for active involvement of student participants;
- A good supply of timely, accurate information on careers, financial aid, college and university allied health programs, admissions and application processes, academic requirements, and student support services.
- Informed, accessible contacts in the allied health programs who are available to answer student questions and provide informal guidance.

The goal of career education is to make minority students, counselors, and advisors aware of the full range of allied health careers and preprofessional academic preparation in order to increase the number of qualified minority applicants in the applicant pool. A complete career awareness program should include strategies to provide students with:

- Exposure and access to minority career role models and the clinical and educational environments;
- Accurate and complete career guidance and counseling;
- Sufficient information regarding allied health careers and educational requirements to prepare them to make informed career and curriculum choices.

Specific strategies for allied health career awareness/student recruitment and retention follow:

B. Allied Health Career Awareness Strategies

Health Career Demonstration Day

Target Audience: High school students, undergraduates, adults.

Health career day activities are a popular and effective means of providing a broad range of career information to a large audience of students, teachers, and counselors. They also provide opportunities to involve parents in career planning and to gather information from students and counselors. For example, the School of Allied Health of Thomas Jefferson University offers Saturday Career Days at various sites with special sessions designed for parents, various levels of students, and counselors and advisors. The success of the program is attributed to widespread community-based involvement and support. Health Career Day objectives include informing students and counselors of the variety of allied health careers, establishing lists of potential applicants, and initiating a relationship with students, advisors, counselors, and teachers.

A variation on this strategy is Health Career Demonstration Day in which, through role playing, the typical activities and functions of members of the health care team are presented. Active demonstrations using participants as simulated "patients" being cared for by the various health professionals are conducted by minority clinicians, practitioners, students, and faculty. Other components include:

- Dissemination of information and literature on allied health careers and preprofessional preparation;
- Visual and multimedia displays depicting subjects related to the preparation, training, and function of allied health professionals;
- Discussions of preparation and curriculum planning, length of study in each profession, and description of the curriculum;
- Information on colleges offering allied health programs;
- Tours of clinical facilities and the educational environment;
- Small group interaction with allied health clinicians and faculty to provide a forum for questions and answers.

Some additional components suggested for undergraduate or adult audiences include:

- Discussions of required undergraduate prerequisites, procedures for transfer of credits, explanation of college support systems, part-time study schedules, admissions requirements, and application procedures;
- Opportunity for individual assessment of a student's college record.

The most important tangible outcome of this strategy is the list of potential applicants and guidance counselor contacts generated.

Career Guidance Personnel Orientation to Allied Health Careers

Target Audience: High school career guidance counselors and science teachers; undergraduate faculty advisors and science faculty.

Counselors, advisors, teachers, and faculty members are important links between students and allied health education programs. If well-informed, they can help to identify potential students and assist their progress. Their need for accurate and complete allied health career information is often as great as that of the students they serve. A working session conducted by allied health faculty and admissions committee members can provide these "mentors" with the information they need to adequately counsel students on careers, financial aid, prerequisite academic preparation, and locations of programs.

The desired outcomes of Career Guidance Personnel Orientation include the establishment of working relationships between school counselors and allied health program personnel.

Multi-media Presentation: Science and Health Care—Partners for Life

Target Audience: Undergraduate and community college science majors, science faculty members, and advisors.

One group of students who are generally well-suited and prepared for an allied health program are undergraduates who are already majoring in the biological or physical sciences. While these students usually have the necessary interest and background, they are largely uninformed of allied health careers in which their science skills can be utilized. Science faculty members and advisors also lack the information to inform students of such careers.

A portable, lightweight, photo essay or other multi-media presentation requires minimum supervision and is a cost-effective way of getting career information to audiences that concentrate in a particular place, as for example, the hallways of science department classroom buildings.

The objectives of the photo essay "Science and Health Care" are:

- To inform undergraduate students interested in or majoring in science of career options in allied health;
- To inform undergraduate science faculty and advisors of career options for science majors;
- To obtain a list of undergraduate science majors interested in allied health careers;
- To provide campus-wide or regional visibility for specific allied health education programs.

The display can provide photographs and informative text to depict the interrelated roles of science and health care, describe career options in allied health, and provide information about specific allied health education programs. Most importantly, it can include a pad of tear-offs that students can fill out and return to receive additional information about allied health careers. At the same time, the allied health programs get the names of potential applicants who are nearing career decision-making.

The display can also be used to obtain campus-wide visibility for allied health information by placing the display on a rotation schedule to include dormitory lobbies, science buildings, cafeterias, and student union buildings. In addition, a duplicate copy can be placed on a similar rotation schedule at other colleges and junior colleges in the area. This type of informative audio-visual presentation is an appealing and versatile resource that can be developed and shared regionally.

Allied Health Essay Contest

Target Audience: Past participants in career awareness activities including high school and undergraduate students.

This follow-up strategy is designed to provide an incentive for initially contacted students to seek more information about allied health care.

The objectives of the strategy are:

- To provide students with additional exposure to minority role models in the educational and clinical environments;
- To provide continued input and stimulation to previously contacted students.

This method requires solicitation of essays on the subject of allied health care and careers by written invitation and sent to students who have participated in at least one previous allied health activity. Individual essays may cover such topics as "The Role of the Physical Therapist in the Health Care Team," "The Need for Blacks in Allied Health," or "The increased Demand for Allied Health Practitioners." Essay parameters and the criteria used to judge essays should be adjusted to accommodate the level of the target audience. It would be helpful to ask an English department faculty member to assist in establishing appropriate composition guidelines to accompany the content guidelines established by members of the allied health faculty.

Provide appealing awards to as many contestants and winners as possible, including small monetary incentives, local recognition, and a more in-depth exposure to the allied health environment (e.g., spend a day or more in the allied health department of the student's choice). As part of the contest experience, all student contestants should be given personal assessments of their level of preparation for study in allied health programs. The personal attention and rewards students receive from this experience are effective in reinforcing interest in allied health science.

Introduction to the Health Professions Course

Target Audience: Undergraduate freshmen and sophomores.

Many schools, as for example Pan-American University and the University of Texas at El Paso, have begun to offer health career guidance and information through a one-credit course in Introduction to the Health Care Systems/Professions. This approach is designed:

- To provide students with a positive orientation to allied health professions as an important part of the health care team;
- To introduce students with an interest in health care to the duties and responsibilities of various health care professionals.

The course includes extensive information dissemination and exchange through discussions, tours of medical and clinical facilities, guest appearances by minority role models, curriculum planning sessions, and academic background analysis.

Enrollment in the course is enhanced by adequate campus publicity, by making it open to any student enrolled in the institution, and by offering credit for the course.

Joint Open House and Career Day

Target Audience: Undergraduate science faculty members and advisors, science majors and undergraduates interested in science and/or health careers.

There is sometimes hesitant interaction and cooperation between science and allied health departments with regard to student advising. However, students will best benefit by exposure

to the broadest possible spectrum of career possibilities. The objectives of this strategy are:

- To build a working relationship and network of information exchange between science and allied health educators in order to provide students with more complete career guidance;
- To inform undergraduate students majoring in science of career options in allied health education.

This joint effort is actually a career demonstration day activity for a special target audience, i.e., students who have already demonstrated an interest in science or health care. The strategy includes career demonstration day components. Since undergraduates will have many concerns about credit transfer, changing departments, and departmental requirements, an important component of the strategy is an information and question forum to address these issues, followed by individual counseling sessions with students. This strategy provides an excellent occasion for allied health educators to actively market the allied health professions along with other science and medical careers.

Allied Health Community Relations Campaign

Target Audience: General public.

Mass media, school media, and audio-visual aides are efficient and cost-effective ways to provide allied health career education to the general public. Most local radio and television stations offer air-time for public service announcements, and radio talk shows and call-in programs readily accept ideas for program topics.

The objectives of the community relations campaign are:

- To utilize a variety of media to obtain high community visibility for allied health careers and education programs;
- To inform the general public of career options and educational programs in allied health.

Audio-visual presentations containing general information and career orientation are appealing and versatile resources that can be developed and shared regionally. The possibilities include slide-tape presentations, student handbooks, multi-media displays, and videotapes. All can be used in career day activities on and off campus, in learning resource centers, public libraries, club meetings, and building lobbies. They can also provide information when no resource person is available to participate in off-campus career awareness programs.

Ideally, the career education strategies already implemented have increased minority student awareness of careers and the level of academic preparation necessary for admission into allied health education programs. However, both students who are well-prepared and those who are less so (academically and emotionally) will be present in any group of students who plan to apply for admission. Recruitment counseling for this heterogeneous group of potential applicants requires an analysis of the complete academic and student profile, as well as a realistic assessment of each student's ability and academic preparedness for admission. The

assessment will be the basis for offering guidance on academic preparedness for students, and how to apply to allied health education programs for those who are able to do so.

This level of more specialized counseling requires the participation of individuals who are familiar with the practical aspects of applications, interviews, financial aid and admissions; additionally, it requires a sensitivity to minority student concerns and an ability to counsel students without false encouragement or unfounded discouragement.

A complete recruitment and counseling program includes strategies to:

- Provide students with information and guidance on the application, interview, admissions, and financial aid processes;
- Provide students with assessments of academic preparation to pursue study in allied health and offer guidance on how preparedness can be improved;
- Provide or refer students to support services designed to help them develop and improve skills in test taking, time management, note taking, memorization, and reading comprehensive;
- Inform admissions committees of both cognitive and noncognitive admissions criteria that can be used to fairly and completely evaluate minority students.

The Pre-admissions Workshop Series

Target Audience: Undergraduate applicants and other potential applicants.

Practical workshops and role play are used to achieve the objectives of this strategy:

- To inform students of and prepare them for the admissions, application, interview, and financial aid processes;
- To provide realistic assessments for all applicants' credentials.

Videotaped simulated admissions interviews, practice sessions to interpret and complete the application form, and practical workshops in financial aid are components used to familiarize students with the mechanical processes of gaining admission to allied health education programs.

It is helpful to solicit the involvement of university personnel such as financial aid officers and admissions committee members in developing and presenting preadmissions workshops.

Adopt-a-Student Program

Target Audience: Undergraduate and high school students.

The objectives of this strategy are:

- To provide personal attention and guidance to promising, motivated students;
- To provide students with interaction with minority role models.

Mentors (current allied health students, faculty, or alumni clinicians) take responsibility for monitoring an assigned student's academic progress and application to an allied health education program. Candidates for guidance include participants in past career education activities and students referred by undergraduate advisors.

The selection of conscientious and informed mentors who will take the time to counsel minority students is necessary for the success of this strategy. Regularly scheduled group conferences of mentors and students can provide opportunities for informal interaction.

Get-Acquainted Lunches

Target Audience: Undergraduate applicants, prospective applicants, transfer students.

A series of noon lunches are used to:

- Provide opportunities for informal interaction between applicants and prospective applicants and allied health faculty members, administrators, admissions committee members, and student leaders;
- Provide a forum for topical discussion of nonacademic aspects of university student life.

Such unpressured interaction can often give admissions committee members additional insight into students whose academic credentials do not completely reflect ability or motivation. The lunches can also allow for topical discussions of subjects which generally have no other forum (e.g., student life on campus, extracurricular activities, organizations, etc.).

Creativity and resourcefulness in the selection of guests to include a well-rounded mixture of students, faculty, alumni, and applicants will yield lively conversation and insightful interaction.

Encore

Target Audience: Rejected applicants of allied health education programs.

It is important for students who have applied but have not been accepted into an allied health education program to receive guidance and/or retraining to increase the applicant's chances for successful matriculation. Sound judgment in advising these students is essential to avoid additional disappointment.

The objectives of this strategy are:

- To provide an analysis and assessment of the applicant's complete student profile (a review of the student's application, academic background, test scores, extracurricular activities, and interview evaluation);
- To identify a student's strengths and weaknesses in order to best advise him or her.

A rejected applicant can best be helped by providing him or her with a realistic assessment of the chances for admission and successful completion of a post-secondary program in allied health.

Alumni Advisory Committee

Target Audience: Community allied health clinicians, educators, and other health care professionals.

The advice, influence, and support that university alumni can provide in implementing career awareness and recruitment programs is invaluable.

The objectives of this group of alumni are:

- To act in an advisory capacity and to act as an information link to the community and to the allied health clinical setting;
- To serve as role models and sponsors of career and recruitment activities;
- To serve as community resources for identifying career-related job experiences, supporting special projects, and generating sources of student financial aid.

Members of an alumni advisory committee need not be limited to allied health professionals, but may include other medical and health care professionals as well as other alumni who are committed to increasing the number of minority students in health education programs.

A particularly effective function that members of the committee can perform is contacting qualified applicants to demonstrate personal interest in the students' career goals and attendance at the alumni's alma mater. The contact can often make the difference in program selection for students who are likely to be accepted to several programs.

Retention Strategies

The primary goal of retention strategies is:

- To provide adequate academic, financial, and emotional support for minority students enrolled in allied health programs in order to improve their chances for successful completion of the programs.

The extent to which strategies will be necessary to achieve this goal rest, in part, on the effectiveness of the admissions committee in selecting capable, prepared students for admission. However, even the most capable student may, for a variety of reasons, begin the educational program with a specific academic deficiency or encounter academic difficulties along the way. Academic, emotional, and financial support and counseling are utilized to help such students overcome obstacles that could interrupt their educational progress.

Student Database System

Target Audience: Undergraduate applicants, potential applicants, and students enrolled in allied health education programs.

Two strategies described so far have been designed primarily to identify potential applicants in order to aid their progress toward a career in allied health. A system to record and track the progress of these students through the educational process is necessary in order to provide complete and accurate guidance and counseling. *Incorporate Word College in San Antonio, Texas has implemented a computerized system of tracking and recording student progress.* The objectives of this strategy are:

- To provide advisors immediately with complete student profiles in order to improve the effectiveness of counseling;
- To minimize the paperwork and time required to record data and generate reports;
- To monitor students' academic progress.

The student database system consists of three files from which information and reports can be extracted: (1) the demographic file, which contains general information on the student; (2) the admissions file, which contains admissions data for both entering freshmen and transfer students; and (3) the course work file, which contains data on college courses for which the student has received credit. From these files, several types of reports can be generated, including demographic reports, reports on students' grades and academic progress, and enrollment reports on the number of students per session enrolled in each required or elective course.

A system of storing and retrieving student data is invaluable in tracking student progress and managing the information needs of students for an active, ongoing career awareness and recruitment program. It is equally effective as an aid to retention by providing constant monitoring of grades and the opportunities for early detection of deficiencies or difficulties.

Student Diagnostic Exams

Target Audience: Applicants accepted into an allied health education program.

This strategy is designed to:

- Identify academic and/or study skills deficiencies in incoming students;
- Prescribe remediation for deficiencies before academic course work in the professional or clinical curriculum begins.

Pre-allied health diagnostic exams are administered to accepted students in order to identify academic and study skills deficiencies. Early detection of deficiencies is important so that remediation can be prescribed before the student must handle the rigors and volume of the clinical curriculum. A student should not have to play "catch-up" during this intensive period of study and adjustment.

Remediation should be prescribed on the basis of each student's needs, cognitive style, and availability for additional study. Being able to accommodate a variety of student needs will require use of learning aids that will accommodate a wide range of student circumstances and cognitive styles, including self-instructional modules, audio-visual aids, programmed instruction, printed material, laboratory or job experiences, etc. The diagnostic exam should be administered early enough to give students adequate time to complete prescribed remediation. In addition, student progress through the remediation should be monitored.

Student Skills Improvement Workshops

Target Audience: Accepted applicants and current enrollees.

The objective of a study skills workshop is:

- To improve and reinforce the academic survival skills of minority students in allied health programs.

Pre-enrollment and ongoing seminars and workshops in reading comprehension, note taking, memorization, test taking, and time management provide opportunities for students to practice and refine study skills on scientific content before having to use the skills in the curriculum.

It is often possible to integrate existing university study skills programs into strategies to address the special needs of allied health education students.

APPENDIX A

AASCU STAFF PARTICIPATING IN THE PROJECT

Staff Member	Title
Dr. Harold Delaney	Project Administrator
Dr. Marcia V. Boyles	Project Director
Dr. Mary Lee Seibert	Associate Project Director
Dr. Geraldine B. Harris	Associate Project Coordinator
Ms. Phyllis Lawrence	Associate Project Coordinator
Ms. Bobbie Primus-Heath	Associate Project Coordinator
Mr. Charles Woodson	Associate Project Coordinator
Ms. Carol McKetty	Administrative Assistant
Mrs. Donna S. Moore	Administrative Assistant

APPENDIX B

PROJECT STEERING COMMITTEE MEMBERS

Full Members

Dr. Benjamin H. Alexander
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(Formerly President, Chicago State
University)

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Dr. Bella J. May
Chairperson
Department of Physical Therapy
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Dr. Donald F. Taylor
Dean, School of Health Related
Professions and Natural Sciences
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Dr. Lucille Tunstall
Chairperson
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Clark College
Atlanta, Georgia 30314

APPENDIX B (continued)

PROJECT STEERING COMMITTEE MEMBERS

Ex-Officio Members

Dr. Donald Buckner
Assistant to the Director
Bureau of Health Manpower
Health Resources Administration, (HRA)
Public Health Service (PHS), Department
of Health and Human Services (DHHS)
Hyattsville, Maryland 20782

Mr. Horace Carpenter
Project Officer
Office of Health Resources Opportunities
(OHRO), HRA, PHS, DHHS
Hyattsville, Maryland 20782

Dr. Mary E. Hawthorne
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Dr. Joseph Kadish
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Health Resources Administration,
PHS, DHHS
Hyattsville, Maryland 20782

Mr. Jack L. Knight
Director, Tribal Management
Support, Office of Research and
Indian Health Service, PHS
Tucson, Arizona 85734

APPENDIX C

INSTITUTIONS PARTICIPATING IN THE PROJECT AND THEIR CAMPUS LIAISONS

Institution	Liaison
ALABAMA A&M UNIVERSITY Normal, Alabama 35762 (205) 859-7222 Dr. Richard Morrison, President	Dr. Jeanette Jones Associate Professor Department of Biology (205) 859-7268
ALABAMA STATE UNIVERSITY 915 South Jackson Street Montgomery, Alabama 36101 (205) 193-4100 Dr. Levi Watkins, President	Dr. Nathaniel Boggs, Jr. Chairperson, Department of Biological Sciences (205) 293-4316
BETHUNE-COOKMAN COLLEGE 640 Second Avenue Daytona Beach, Florida 32015 (904) 255-1401 Dr. Oswald P. Bronson, President	Ms. Bobbie Primus-Heath (1979-81) Dr. Premsukh Poonai (1981-83) Professor of Biology
*CHICAGO STATE UNIVERSITY 95th Street at King Drive Chicago, Illinois 60628 (312) 995-2000 Dr. George Ayers, President	Dr. Anderson J. Ward Dean, College of Allied Health (312) 995-2552
*CLARK COLLEGE 243 Chestnut Street, NW Atlanta, Georgia 30314 (404) 681-3080 Dr. Elias Blake, Jr., President	Dr. Lucille Tunstall Chairperson, Allied Health Professions Department

- * These schools were "demonstration schools"; they had well-established allied health programs prior to the project's commencement and therefore served as models for the other institutions.

Institution	Liaison
DILLARD UNIVERSITY 2601 Gentilly Blvd. New Orleans, Louisiana 70122 (504) 283-8822 Dr. Samuel DuBois Cook, President	Mrs. Beryl Segre, MPH Assistant Professor Health Education
FLORIDA A&M UNIVERSITY Tallahassee, Florida 32307 (904) 599-3210 Dr. Walter L. Smith, President	Dr. Jacqueline Beck Dean, School of Allied Health (904) 599-3818
GRAMBLING STATE UNIVERSITY Grambling, Louisiana 71245 (318) 247-6941 Dr. Joseph B. Johnson, President	Dr. Phillip Young Associate Dean College of Arts & Sciences (318) 247-6442
HAMPTON INSTITUTE Hampton, Virginia 23668 (804) 727-5231 Dr. William Harvey, President	Dr. James B. Abrams, Jr. Deputy Chairman Department of Biology (804) 727-5282
INCARNATE WORD COLLEGE 4301 Broadway Street San Antonio, Texas 78209 (512) 828-1261 Sister Margaret Slattery, President	Dr. John Ward Chairman, Natural Science Division
INTERAMERICAN UNIVERSITY OF PUERTO RICO San German Campus San German, Puerto Rico 00753 (809) 892-4320 Dr. Federico M. Matheu, Chancellor	Dr. Glenn Price (1979-81) Dr. William Stephens (1982-83) Chairman, Department of Chemistry Sra. Astrid Morales (1981-82)

Institution	Liaison
KNOXVILLE COLLEGE 901 College Street, NW Knoxville, Tennessee (615) 524-6500 Dr. Clinton Marsh, President	Dr. Mary Brown Chairperson Biology Department (615) 524-6544
*NORFOLK STATE UNIVERSITY 2401 Corprew Avenue Norfolk, Virginia 23504 (804) 623-8670 Dr. Harrison B. Wilson, President	Dr. Donald Taylor Dean, School of Health Related Professions & Sciences (804) 623-8180
*PAN-AMERICAN UNIVERSITY 1201 West University Drive Edinburg, Texas 78539 (512) 381-2011 Dr. Miguel Nevarez, President	Mr. Julian Castillo Director, Division of Health Related Professions (512) 381-2291
TALLADEGA COLLEGE 627 West Battle Street Talladega, Alabama 35160 (205) 362-2752 Dr. Joseph Gayles, President	Dr. Arthur L. Bacon (1979-82) Chairman, Natural Sciences and Mathematics Dr. Charles Stinson (1979-83) Associate Professor of Biology
*TENNESSEE STATE UNIVERSITY 3500 Centennial Blvd. Nashville, Tennessee 37203 (615) 320-3420 Dr. Frederick Humphries, President	Dr. Andrew Bond Dean, School of Allied Health Professions (615) 320-3486

* These schools were "demonstration schools"; they had well-established allied health programs prior to the project's commencement and therefore served as models for the other institutions.

Institution	Liaison
TUSKEGEE INSTITUTE Tuskegee, Alabama 36088 (205) 727-8011 Dr. Benjamin Payton, President	Dr. Theodore Childs (1979-82) Dr. James Hefner (1982-83) Provost (205) 727-8164 Ms. Marie Moore (1982-83) Chairperson, Division of Allied Health (205) 727-8491
UNIVERSITY OF MARYLAND- EASTERN SHORE Princess Anne, Maryland 21853 (301) 651-2200 Dr. William Hytche, Chancellor	Dr. Thomas Hopkins Chairman, Department of Natural Sciences
UNIVERSITY OF TEXAS-EL PASO El Paso, Texas 79968 (915) 747-5000 Dr. Haskell Monroe, President	Dr. Gordon Robertstad (1979-81) Ms. Mary Hume (1981-83) Coordinator, Allied Health Programs (195) 544-1880
VIRGINIA UNION UNIVERSITY 1500 North Lombardy Street Richmond, Virginia 23220 (804) 257-5600 Dr. David Shannon, President	Dr. William Waller (1979-80) Dr. Randy Johnson (1980-81) Dr. Sam Roberts (1981-83) Dean, Academic Affairs
WINSTON-SALEM STATE UNIVERSITY Winston-Salem, North Carolina 27102 (919) 761-2011 Dr. Douglas Covington, Chancellor	Mrs. Betty Alexander Chairperson, Medical Technology (919) 761-2097

APPENDIX D

PLANNED NEW ALLIED HEALTH ACTIVITIES OF PARTICIPATING INSTITUTIONS

Institution	Activity
Alabama A&M University	Development of Programs in: CUP Dietetics; Co-operative Medical Technology and Mental Health
Alabama State University	Development of a Medical Care Management and Health Planning Program
Alabama Consortium: (Alabama A&M University; Alabama State University; Talladega College; and Tuskegee Institute)	Institutional Partnership Program in Allied Health
Bethune-Cookman College	Development of a Baccalaureate Program in Mental Health, and of a Physical Therapy Linkage Program with the University of Florida, and Georgia State University
Chicago State University	Development of a Rehabilitation Therapies Teaching Clinic. Development of Programs in Occupational Therapy and Physical Therapy.
Clark College	Development of Radiologic Technology and Occupational Therapy Linkage Programs.
Dillard University	Development of Cooperative Allied Health Programs.
Florida A&M University	Development of Programs in Physical Therapy, Respiratory Therapy, and Health Care Management.
Grambling State University	Development of a Linkage Program with Louisiana State University for Six Allied Health Programs. Health Career Awareness and Student Recruitment Program.
Hampton Institute	Development of an Integrated Medical Technology Program and a Program in Physical Therapy.

Institution	Activity
Incarnate Word College	Development of a CUP Dietetics Program and Improvement of Instruction in Medical Technology.
Inter-American University of Puerto Rico	Development of an Allied Health Science Core, and Development of Four Allied Health Programs (CUP Dietetics, Speech Pathology/Audiology, Medical Records, Respiratory Therapy) and a Audiovisual Lab.
Knoxville College	Development of a Career Ladder Health Sciences Program in Medical Transcription, Medical Assisting, and Health Administration.
Norfolk State University	Improvement of Counseling and Teaching Capabilities in Allied Health.
Pan American University	Development of a CUP Dietetics Program, and Development of a Linkage Program to Increase Hispanic Student Access.
Talladega College	Development of a Health Career Awareness Counseling, and Retention Program.
Tennessee State University	Development of a Comprehensive Student Recruitment/Retention Program. Improvement of the Speech Pathology/Audiology Program. Development of an Occupational Therapy Program.
Tuskegee Institute	Improvement in the Physical Therapy Program and Formation of a New Allied Health and Nursing Unit.
University of Maryland, Eastern Shore	Development of programs in Physical Therapy CUP Dietetics and Occupational Therapy; and the Formation of a New Allied Health Administrative Unit.
University of Texas, El Paso	Development of a Career Counseling Program for Hispanic Students, and Improvement of the Medical Technology Program.
Virginia Union University	Improvement of Programs in Medical Technology and Medical Social Work. Development of Linkages with Medical College of Virginia.
Winston-Salem State University	Development of a Career Awareness/Recruitment Retention Program for Medical Technology. Development of New Programs in Health Administration and Medical Records Administration.

APPENDIX E

SAMPLE INSTITUTIONAL FEASIBILITY STUDY

Introductory Summary

This study was done to determine which allied health programs and/or activities appear most feasible for X College to augment or implement in light of manpower needs, student interest, clinical potential, and institutional capability.

The program areas considered were medical technology (program underway), health education, and linkages for physical therapy with existing professional schools. Manpower needs in all three areas were documented and are sufficient to support employability of graduates in the geographic region of the college. Student interest was assessed and with appropriate recruitment efforts, building enrollment in the programs should not be a problem. Clinical potential for medical technology and health education practicums and for physical therapy related experiences for pre-professional students were assessed and appear excellent. The medical community is actively supportive of X College's efforts in these allied health areas. Institutional capability for operating the medical technology (2 + 2) program appears assured for the first year through the acquisition of external funds. Continued support will depend upon allocation of institutional resources and program enrollment. Institutional capability for the implementation of the health education program at this time depends upon potential acquisition of external funds and/or cross-utilization of personnel employed to assume other responsibilities in the coordination of allied health related activities. The institution should be able to work out linkages for physical therapy using existing (or replacement) personnel responsible for allied health coordination. Some funds may be necessary, but until the details are worked out, the need is not known.

Introduction

The purpose of this study was to determine the allied health activities and/or programs most suitable and practical for X College to augment or develop in light of manpower needs, student interest, clinical potential, and institutional capability.

Manpower needs have been assessed by the campus liaison through communication with the state Health Systems Agency, performance of a needs assessment survey (currently underway and funded by the X County Heart Association), and discussions with personnel in health service facilities in the area. Critical manpower shortages exist in the medical laboratory area and physical therapy. Shortages also exist among personnel to conduct community health education as well as practitioners to staff medical records departments in area hospitals.

Student interest was determined by a survey of nearly 1,000 potential college students: Approximately two percent indicated interest in an allied health occupation. The programs being considered or offered by the college (i.e., medical technology, health education, and preprofessional physical therapy) were listed as top priorities by potential students.

The establishment of agreements for clinical cooperation with the medical technology program looks very strong. In addition, the general groundwork for future efforts in a variety of areas has been well done. It appears that broad support from the medical community and the health agencies exists for allied health efforts at X College.

The major limitation for the future development of allied health programs is, not surprisingly, the availability of funds for start-up and operation. The administration of X College is philosophically committed to their development.

Programs/Activities Considered

Medical Technology: this program will be implemented as a college-based, 2 + 2 (integrated) curriculum in the Fall Semester, 1981. Two faculty with Ph.D.'s are currently employed. Two more faculty are scheduled to be hired before fall. Because of the foresight exercised in hiring initial faculty at the Ph.D. level and because of the expertise in the clinical areas, more flexibility is possible in hiring faculty for their clinical and teaching expertise rather than academic degrees (at the doctoral level). Laboratory facilities have been renovated and await furniture. Equipment has been purchased. The curriculum has been submitted to the accrediting agency (NAACLS) and received preliminary approval as a developing program. The primary concern, now, is recruiting adequate numbers of qualified students.

Physical Therapy: the potential for a pre-professional linkage between the College and institutions offering the professional program in physical therapy has been discussed with representatives from Y University. Such a linkage should serve to enhance the likelihood of students being accepted into the program by enhancing career counseling, allowing for early identification of potential students, acquainting faculty from the professional program with interested students at X College and continuously maintaining the relevancy and acceptability of pre-professional course work through open communication between institutions. Linkages might also involve dual degrees, cross-utilization of personnel, or other activities that enhance the relationships. To develop and coordinate such a linkage or linkages, an individual on X College campus (faculty) would be necessary (part-time). The duties of the coordinator would likely include:

- Working out the curricular mesh of prerequisites with linkage institutions;
- Working out agreements for the linkage, i.e., dual degrees, orientations, etc.;
- Coordinating the linkages, i.e., meeting with personnel at both institutions to maintain open communication and keep abreast of administrative and curricular changes;
- Counseling students;
- Developing a proposal for the academic affairs committee regarding dual degree methodology.

Health Education: the curriculum for a baccalaureate level health education program has been developed. The next step is faculty acquisition for program implementation. The curriculum contains 32 credit hours of specific course work for health education spread over two academic years. A suggestion for an implementation plan is appended to this report.

Medical Records Administration: The implementation of this program is viewed as a long range goal (three to five years). Student interest appears viable. Specific planning for this program is not yet underway.

Campus Liaison to the Project

Since the allied health coordinator for X College has left, it will be necessary to appoint a replacement for her. The individual chosen should be one who:

- Has a background in education and experience in allied health education and/or grant writing and management;
- Has responsibility at the College for allied health program development and coordination.

Institutional Capability

The climate for the development of allied health programs at X College is very good. The clinical agencies are very supportive, the faculty and the administration are philosophically committed, students are interested, and manpower needs in the area are acute. Funding is the major drawback.

Recommendations

- That AASCU project staff immediately assist in recruitment of medical technology students by notifying all project participating institutions of the availability and nature of the program (done 2/25/81).
- That X College pursue the development of formal mechanisms/linkages with existing physical therapy programs (and others) so that students interested in pursuing allied health careers not available at the College might move more smoothly into these programs, while, at the same time, completing a dual degree at X College. A consultant with experience in the development of such linkages may be helpful in this area. The AASCU project could assist with locating such a person and assume the cost, if requested to do so by X College.
- That consideration be given to starting the health education program as soon as possible with existing institutional resources and that external funds be sought for further program support. The AASCU project will assist, if requested, in locating potential funding sources.

- That X College plan an appropriate administrative structure for allied health programs and activities that will accommodate existing programs, those under development, and those forecasted for the future.
- That a replacement for the campus liaison to the AASCU project be named as soon as possible.

APPENDIX F

RECOMMENDED CONSULTANTS USED BY THE PROJECT

Name and Affiliation	Specialty
Patricia Amos, MS Chairman Allied Health Department The University of Alabama in Birmingham	Medical Technology
Kamala Anadam, EdD Director Computer-Based Instructional Development and Research Miami-Dade Community College	Computer Science
Robert E. Ayers, MS Associate Professor and Director Physical Therapy Program Hunter College	Physical Therapy
JoAnn Brooks, RRI Department Director Medical Records Administration Wade County Medical Center	Medical Records
Mildred Cash, MA Associate Professor and Director Medical Records Administration Program Medical University of South Carolina	Medical Records
Clementine Coleman, MA Director, Medical Technology Program School of Health Professions Governors State University, IL	Medical Technology
Donald T. Counihan, PhD University of Oklahoma Jogh Keys Speech and Hearing Center University of Oklahoma Health Science Center	Speech Pathology

Name and Affiliation	Specialty
David Dunn, DrSc Head Department of Health and Safety Western Kentucky University	Health Administration
Harley Flack, PhD Dean, College of Allied Health Howard University	Allied Health Linkages
Ruth Franklin, EdD Department of Home Economics Texas Christian University, TX	Dietetics
Scott Gregory, PhD Director Respiratory Therapy Medical College of Georgia	Respiratory Therapy
Richard Haak, PhD Department of Microbiology and Biophysics Indiana University	Preprofessional Curriculum
Celestine Hamant, MS Indiana University Medical Center	Occupational Therapy
Everlena Holmes, PhD School of Allied Health Professions Tennessee State University	Medical Records Administration
James W. Hunter, BA School of Medicine Division of Allied Health Professions Vanderbilt University	Respiratory Therapy
Bernard Kincaid, PhD Director of Planning School of Community and Allied Health University of Alabama at Birmingham	Health Administration

Name and Affiliation	Specialty
Nicholas Linares, PhD Assistant Professor and Head Department of Communicological Disorders College of Health Related Professions University of Puerto Rico	Speech Pathology
Lena A. Llorens, PhD Professor, Chairperson and Graduate Coordinator Department of Occupational Therapy College of Health Related Professions University of Florida	Occupational Therapy
Colin R. MacPherson, MD Division of Laboratory Medicine University of Cincinnati, OH	Medical Technology
Winifred W. Mauser, MS American Physical Therapy Association	Physical Therapy
Bella J. May, PhD Chairperson Department of Physical Therapy Medical College of Georgia	Physical Therapy
Barbara Noel, PhD. Professor, Department of Music and Drama Texas Women's University	Music Therapy
Donna C. Odom, MA Associate Professor Department of Medical Technology School of Allied Health Professions Virginia Commonwealth University	Medical Technology
Elaine O. Patrikas, MA Chairman and Professor Department of Health Records Administration Temple University, PA	Medical Records
Nancy Prendergast, MEd Professor and Chairman Department of Occupational Therapy School of Allied Health Sciences Medical College of Georgia	Occupational Therapy

Name and Affiliation	Specialty
Glenda Price PhD Assistant Dean College of Allied Health Professions Temple University, PA	Medical Technology
William Primus, EdD Chairman and Professor Department of Behavioral Studies Miami-Dade Community College, FL	Institutional Packaging
Ivy Reade, BS Executive Director American Association of Medical Assistants	Medical Assisting
Ann McPherson De Sanchez, MS Mayaguez Medical Center Puerto Rico	Dietetics
Jeanne Schenck, MA Professor Emeritus University of Texas, Medical Branch	Physical Therapy
Mary Lee Seibert, EdD Dean College of Allied Health Professions Temple University, PA	Allied Health Feasibility Curriculum Development
Juanita Sirmans, AB Professor Emeritus Medical College of Georgia	Medical Records Administration
Margaret K. Snowman, PhD Associate Professor Department of Human Nutrition Syracuse University, NY	Dietetics
Shirley Steffee, BSN New York University Medical Center	Respiratory Therapy

Name and Affiliation	Specialty
Steven Sundre, PhD Vice President Association of University Programs in Health Administration	Health Administration
Robert Thorpe, EdD Division of Radiologic Science University of North Carolina	Radiological Sciences
Ann W. Tourigny, PhD Director Office of Undergraduate Education Association of University Programs in Health Administration	Health Administration
Marie Vittoe, EdD Department of Medical Technology University of Kentucky	Medical Technology/ Allied Health Education
Sara Wise, PhD Assistant Professor University of Utah	Medical Technology
Patricia Yarbrough, PhD Director of Education American Physical Therapy Association	Physical Therapy
Gerald Zimmerman, PhD Assistant Professor Indiana University School of Medicine	Preprofessional Curriculum

APPENDIX G

Sample Consultants' Report

X University appears to be an excellent site for implementing a Medical Record Administration program. The University has the support facilities necessary for such a program and the administration is committed to allied health education. The University is aware of some of the differences between allied health education and liberal arts education and appears to be willing to appropriately deal with these differences.

It is recommended that the University contact the American Medical Record Administration for the informational packet which is available for all schools and universities interested in medical record educational programs. This information is very detailed and quite helpful to institutions. It includes a copy of the *Essentials of an Accredited Educational Program for the Medical Record Administrator* and guidelines for the *Essentials*. These documents give the qualifications for the Program Director, requirements for facilities, course content, and other information which is extremely valuable in the earliest planning stages of such an educational program.

The city of Y, where the University is located, offers untold opportunities for student exposure to various types of health care facilities, systems, and methodologies. Each medical record practitioner contacted was asked specifically if she anticipated any problems with working with a predominantly Black college and with predominantly Black students. In each case the answer was negative. Some of these individuals have been known to this consultant for many years and it is felt that the city's medical record community would be supportive of a medical administration program in the area and would welcome an opportunity to work with the University in the planning of the Program, recruiting of a Program Director, and supporting clinical education for the students. Two resource individuals who would be very helpful to X University and who have expressed an interest in helping are Ms. Mary Jones, RRA, ABC Hospital, and Ms. Jane Smith, RRA, DEF Hospital.

Clinical Resources

Y City provides an abundance of appropriate clinical sites for the education of medical record administrators. There are available large teaching institutions, small general hospitals, ambulatory care facilities, psychiatric facilities, long-term care institutions, nursing homes, and specialty institutions. Within these there are represented all the needed medical specialties from the routine, i.e., medicine, surgery, obstetrics, pediatrics, etc., to the more unusual specialties, i.e., neonatology, nuclear medicine, oncology.

Three facilities were visited: GHI Hospital, JKL Hospital, and MNO Hospital. Each would be an excellent site for clinical practice in various areas of medical record education. GHI Hospital would probably be of minimal value under the present circumstances as there is no RRA in charge of the Medical Record Department. In both of the other facilities, the departmental directors were interviewed and each expressed an interest in taking students

for their clinical experiences. Both JKL and MNO Hospitals have a great deal to offer from the standpoints of technical learning, systems development, and strong managerial leadership.

In addition to the clinical facilities, there is available a computer company which employs an RRA to develop and market information systems designed specifically to meet the needs of medical records as well as other health care areas. The RRA is Mrs. Susan Brown, who has an excellent background in medical record practice, medical record education, as well as computer expertise.

Each medical record administrator interviewed was asked specifically if she would have any objection to taking students from X University. Each stated emphatically that there was no objection and that she did not see any difficulties with these students working with their employees.

Each medical record administrator was asked if she felt the other hospitals in the city would be agreeable to taking students from X University. Each stated she felt other hospitals would not only be interested but would be eager to have students. Each named several additional institutions which she felt sure would be more than happy to help with the educational endeavor. It was stated, of course, that any affiliation would have to have the approval of the institutional administrators but none seemed to feel there would be problems.

It is the opinion of this consultant that Y City contains a veritable gold mine of clinical sites for medical record administration students and it would be a real loss to our profession not to make use of these sites.

Facilities Available

The University has the space to house a medical record administration program appropriately. The exact location was not pinpointed but this consultant was assured the space was there and would be made available.

An up-to-date, well-stocked library is currently present on the campus. Some additions which relate specifically to medical record administration and other areas of health care will need to be made to the library. There appears to be no difficulty in getting funding for the necessary additional books and periodicals.

Classroom space is shared by all departments at the University. There are adequate classrooms to make one available to the medical record administration program on a scheduled basis.

Equipment Available or Needed

Excellent audio-visual equipment is available in the University and would be used by the medical record administration students and faculty. The quality and variety of audio-visual equipment exceeds that currently available for many existing medical record administration programs.

There is an on-campus computer which would be available for student use. A CRT is also available for use in the medical record laboratory. Computer software for medical records could probably be obtained from one of the local hospitals.

Equipment needed would include furnishing of at least three offices for the Program, one each for the Program Director, the Assistant Program Director, and a secretary.

The typing laboratory should contain at least six typing desks, each equipped with a typewriter, a transcription unit, and a secretarial chair. The typing laboratory should be covered with acoustic tile. A carpet or some other means of noise abatement is also recommended.

The medical record laboratory should contain modular desks in order that it may serve many purposes, i.e., conference room, seminar discussion groups, and classroom for those units which need to be taught in such a setting.

A space should be provided for a small library of references and periodicals which would pertain specifically to medical record administration. This is desirable to provide easy access to professional publications, to encourage frequent student use of current publications, to aid faculty in keeping current with changes in the field and to provide materials unique to the needs of the program which may or may not be available in the larger general library. While the location of this library within the medical record laboratory is not absolutely necessary, it should be located within the medical record administration program area.

The laboratory should also have an open shelf filing unit. A unit five or six shelves high and nine feet long should be adequate. This would be used to house actual medical records as well as examples of various types of filing folders and different methods of filing. The medical records could be obtained from a hospital which microfilms records. It is understood that all identifying information would be removed from the medical records prior to placing them in the laboratory. The removal of identifiers would be a matter of real concern for the hospitals. It is suggested that Mrs. Jean Gray, RRA, at MNO Hospital be contacted concerning obtaining medical records for students use. The matter of obtaining actual medical records for the University was discussed with Mrs. Gray and it is felt she can be of significant help in this area.

The laboratory should also contain supplies and material appropriate to demonstrate health record systems and methods, allow for student skill development in technical areas and preparation of individual group projects. Storage space for the materials should be provided in the laboratory or should be easily accessible to the laboratory.

A CRT would be needed in the laboratory to provide students with access to the in-house computer and appropriate data.

Potential for Faculty Recruitment

It cannot be stated with any degree of certainty that X University would have little difficulty in recruiting qualified faculty for the medical record administration program. It is true that nationwide there is a shortage of educators in the medical record field. It is also true that

there are a number of RRA's in the Y City area, some of who may desire to become educators should the opportunity present itself.

The faculty benefit package at X University is certainly competitive with those in other universities and in many respects is a more attractive package.

The University administration has demonstrated an interest in and a commitment to the medical record administration program. This fact alone would be helpful in recruiting.

A change in the current University organization structure would probably be necessary before a Program Director could be recruited. Presently, the only other allied health program on the campus is located in the Division of Natural Sciences. A Division of Allied Health Education should be created to house the current program as well as the proposed medical record administration program. The needs of allied health programs are different from those of liberal arts programs. Without a division devoted to allied health, headed by an individual who is cognizant of the special needs of this type of education, the potential of recruiting a Program Director is minimal, if nonexistent.

It is suggested that a search committee for a Program Director be formed which contains at least two RRA members from the Y City regional association of medical record practitioners.

Possible Contributions of Faculty Already Employed

A study of detailed course outlines was not made, but on surface examination, the following courses currently offered at X University appear to be appropriate for medical record administration students:

Biology

- 201 Anatomy and Physiology
- 202 Anatomy and Physiology

Business Administration

- 311 Principles of Management
- 312 Personnel Management

Mathematics

- 204 Probability and Statistics

There does not appear to be a computer course currently offered in the curriculum which would meet the needs of medical record students; however, the chairman of the computer department assured this consultant that the needs for computer education could and would be met. There are courses in research methodology which, with some adaptation, could also meet these needs. There are plans at the University to introduce a course in Introduction to Allied Health; it was the opinion of those present that this course would also fit nicely in the medical record administration curriculum.

Professional Courses Needs

A course in Medical Jurisprudence is a must and this should be taught by a lawyer. The officials at the University felt obtaining an appropriate instructor for such a course would present no problems.

The professional material listed below must be taught but its arrangement, either in separate courses or as units within courses would be the decision of the professional medical record faculty and the curriculum committee of X University:

Medical Terminology Record Management, Health Information Management, Management Foundations, Management Technology, Resource Management, Management of Human Resources, In-Service Education, Utilization and Evaluation of Health Care Services, Health Care Delivery System, and Clinical Practice to reinforce the professional course content.

Potential Student Capacity

The potential student capacity will be dictated by the faculty of the medical record administration program and the number of clinical facilities which are willing to take part in the clinical practice. It is suggested that with a faculty of two full-time faculty members, the entering class be no larger than six students. This would allow the faculty time to address the inevitable problems attendant upon the start-up of a new program. It is assumed that the program director would be on campus at least a year prior to the beginning of the program for planning purposes and for making the necessary contacts with the clinical facilities.

It appears that X University has the capability to eventually take an entering class of fifteen to twenty provided the number of faculty members is expanded appropriately and enough appropriate clinical facilities are willing to take students for clinical education.

Estimate of Funds Required for Program Start-up and Operation

Personnel:

Program Director	\$28,000-35,000
Assistant Program Director	\$24,000-31,000
Full-time Secretary	Dependent upon area salaries

Equipment and Supplies:

The cost of equipment and supplies cannot be accurately estimated because of the vast difference in such costs from one area of the country to another. Any figures given will be rough estimates.

Offices for the Program Director, Assistant Program Director and Secretary:

Furnishings of these offices would include storage space for student records, teaching materials, and references for each individual instructor.

Typing Laboratory:

Six typing desks, six typewriters, six transcribers, and six typing chairs. Material for transcription practice obtained either from clinical facilities or from the American Medical Record Association.

Medical Record Laboratory:

Modular tables to seat fifteen students. Desk, chairs, filing cabinets, three (minimum) storage cabinets for materials, computer terminal. Shelves for a small professional library. Books and periodicals, approximately two thousand dollars (\$2,000). Teaching and practice supplies, approximately five thousand dollars (\$5,000). Open shelf files, approximately one thousand dollars (\$750-\$1,000).

APPENDIX H

Affiliation Agreements-Contracts

Allied Health Education Clinical Affiliation Agreements

Anderson J. Ward, Ph.D., J.D.

Allied health professions education programs are offered in practically every type of postsecondary educational setting. They are found in postsecondary vocational training programs, junior colleges, four year colleges and universities and at the graduate level. Equally diverse are the ways in which these educational settings provide clinical training experience for students.

Some allied health education institutions build clinical training components into the program itself, awarding both an academic degree and professional certification. Others offer only the academic training, requiring students to obtain their clinical training elsewhere, usually from hospital based programs. In these latter situations, the academic institution offers the degree while the clinical facility certifies professional competency. A third variation is the education institution which offers a basic health sciences curriculum culminating with a degree, but does not provide a mechanism for achieving clinical proficiency. Among training programs of this third type, it becomes the student's responsibility to attain his/her clinical proficiency after graduation; again, usually from a hospital based program. A fourth variation is the institution that offers a "pre" allied health curriculum which while providing a fundamental health sciences curriculum expects students to transfer to upper division programs elsewhere should they elect to continue pursuing an allied health profession.

There are other variations on the four fundamental models of allied health education. No matter, though, what route of training an institution takes, all are sooner-or-later faced with the issue of developing, implementing and operating under clinical affiliation agreements. Those institutions which provide only academic training, leaving professional training to be a postgraduate concern for the student, and those which provide only preprofessional training, have oftentimes elected those approaches to avoid the very issue of clinical affiliation agreements, together with their implications and responsibilities. Institutions which do provide clinical training, in one way or another, must make some very basic decisions concerning what best meets students needs. Oftentimes this means determining in advance the probability of students being able to locate and successfully matriculate in a hospital based training program. On this point, the American Medical Association's Department of Allied Health Education and Accreditation recently reported that between 1976-1981 there was an 8.7% (N=263) increase in allied health education programs accredited by the Committee on Allied Health Education and Accreditation. However, the operational base distribution of those programs showed the following changes:

Hospitals	-16.1%
2 Yr Col and Voc/Tech	+11.3%
4 Yr Col/Univ	+ 5.4%
Others	- 0.6%

These data indicate the rather precipitous decline of hospital based programs. Implied in that decline is the probability that any particular student's success in locating a hospital based clinical program has similarly declined. During the 1978-1981 interval graduates did decrease although the programs increased, to wit:

1978 - 38,000 graduates
1981 - 34,500 graduates

One possible explanation for this 9.2% decline of graduates is that although academic programs have increased, the number of clinical spots available to the general student population sharply decreased, thereby diminishing the number of graduates.

Academic institutions must also reckon with the issue of how much or how little control they wish to exert over the clinical training components of allied health education programs. Those willing to accept clinical training without exerting oversight control, may be more willing to accept block time clinical training and to award block academic credit for that training. Conversely, academic standards at off-campus program sites, may be less willing to do so. In fact, professional associations and accreditation agencies do exert substantial pressures on academic institutions to monitor clinical training programs, thus assuring not only the quality of clinical training but also protecting the interests of students.

There are, of course, many other factors that academic institutions must consider relating to general decisions about how allied health education programs are structured and operated. For present purposes, however, the above examples serve to underscore the fact that academic institutions interested in or engaging in the education of allied health professionals must address the question of clinical affiliations. Once that question is addressed, the issue becomes one of how close or how distant that relationship will be. In most cases, some form of clinical affiliation agreement will be developed, if for no other reason than to satisfy accreditation essentials of most professional associations. Once the clinical affiliation agreement is developed it becomes a very important working document for both parties to the educational process and, of course, carries with it certain privileges and legal obligations.

AFFILIATION AGREEMENTS – CONTRACTS

Any agreement, written or otherwise, between individuals or institutions takes on the legal character of a contract. A contract may be defined as a legal device used to ensure the performance in the future of commitments made in the present. Academic institutions educating students in the allied health professions oftentimes could not operate effectively without assurance of future performances by their clinical affiliates. Therefore, in developing, implementing and operating under clinical affiliation agreements, those program personnel charged with the responsibility of operating the program must have at least some basic knowledge of contract law.

The contractual relationship between institutions is always voluntary, and thus the resulting obligations are self-imposed. Given their voluntary nature, courts generally will enforce promises made within affiliation agreements. However, little known by allied health educators is the way in which courts usually go about enforcing contractual promises.

Contractual disputes are resolved under so-called equity principles of law. Legal considerations under equity principles of law are broad, but important among them for allied health education institutions is a little known point about legal remedies for resolving contract disputes. Specifically, while courts will enforce promises made under circumstances which satisfy the essential elements of a contract, the usual remedy for breach of contract is not "specific performance" but rather a judgment for money damages. This procedure recognizes that on the one hand an individual or institution cannot be forced to do something it desires not to do, while on the other hand an injured party should have satisfaction for any injury caused by another's failure to perform through no fault of the injured party. Further, by awarding money damages for breach of contract, equity courts not only satisfy the injury to the aggrieved party but, in effect, penalize the breaching party for having failed to fulfill its previous promises.

To be a legal contract, among other things, the clinical affiliation agreement must be (1) an agreement between legally competent parties, (2) based on the parties *genuine assent*, (3) supported by *bargain-for consideration*, (4) made for a *purpose not in violation of public policy* and (5) in the *form required by law*. Looking at each of these requirements individually, it becomes clear even to the nonlawyer of what is and is not a contract.

1. Legal Competency

The doctrine of legal competency refers to the legal capability of a person to create binding contracts. In general, any adult or other legal entity, such as a corporation, can create binding contracts. There are, however, some exceptions to this general rule, such as age (e.g., minors) and mental aberration (e.g., insanity or intoxication.) Within academic institutions the question of legal competency to create a binding contract often arises around the issue of *who* has the authority to bind that institution. Academic institutions as well as health care facilities, as a general rule, operate under corporate structures. Enabling documents of those corporations (e.g., articles of incorporation, bylaws) typically specify who has the legal capacity for contractually binding the corporation. Silence on this point in the enabling documents creates the presumption, in most states, that only the corporation's directors and/or officers have that authority. However, even though that be the case, another equity principle comes into play on this issue. Specifically, a corporation cannot deny the legality of its contracts on the basis that an unauthorized, legally incompetent, person executed the contract if there is proof that the legally competent party knew or should have known that the incompetent party was in fact purportedly obligating the institution. This equitable principle takes on major implications in allied health education.

Contemporary allied health education programs often have numerous contracts with clinical affiliates. Oftentimes, one program executes several different contracts with several different facilities for several different clinical experiences of its students. In other words, the day of a single clinical affiliate per program is practically extinct. At the same time, allied health education institutions and their students are necessarily of secondary importance to a clinical affiliate's prime purpose of delivering health services. This means that clinical affiliation agreements oftentimes are struck with short lead times and cover short contractual periods.

The implication of all this is that an academic institution must rely on the day-by-day working knowledge of program needs and clinical capabilities held by its program directors or allied health chairpeople. Further, since many institutions operate so many different programs, there may be several program directors involved.

To exemplify this point, it is quite typical that student assignments to clinical facilities are arranged by casual methods such as telephone calls or correspondence. Each of these casual arrangements, in effect, may constitute an informal contractual obligation between the two institutions. Implied then, is the probability that the chief executive officer of either institution, either knew or should have known that his/her program personnel were arranging contracts, albeit informal and casual, for the institution. Therefore, it could be extrapolated that those same individuals also had implied authority to bind the institution under written contractual agreements.

The concern of all this is that allied health education programs generally operate on a short-term basis and at the program level. Generally, it is the program personnel that arrange student assignments to various clinical institutions. These assignments may constitute informal contractual relationships about which the institution's officers either knew or should have known. Therefore, it may be that program personnel, although on the surface legally incompetent to make contracts for that institution, may impliedly not be so legally incompetent.

2. Genuine Assent

The concept of legal genuineness of assent is fairly straightforward. In essence, this doctrine requires that the parties to an alleged contract genuinely intend to assent to the terms of that contract at its writing or other time of agreement. There are, however, a number of circumstances which may cause one's genuineness of assent to fall under suspicion and so, in turn, affect the enforceability of a contract. In general, it is a *mistake* which brings into question the genuineness of assent to one party to an agreement. For example, if a party is unaware that the subject matter of the agreement had ceased to exist before the contract was made, then the contract is unenforceable. The second factor often associated with the doctrine of genuineness of assent is *misrepresentation*, the most extreme extension being *fraud*. Obviously, misrepresentation and fraud are not generally issues in contractual agreements between educational institutions and clinical affiliates. Still, allied health education institutions and their clinical affiliates must know about the to which they are agreeing. Otherwise, a purported affiliation agreement may be unenforceable or voidable.

Having identified some circumstances that create a cloud of suspicion over the genuineness of one's assent, what circumstances create the opposite presumption; that is, that one's assent is genuine? Terms and conditions of contracts are determined through the process of negotiation, no matter how intense or how casual that process might be. Contractual negotiations can always be broken down to their simplest elements; namely, offers, counteroffers and acceptances. Realistically, each point can be reduced to these elements, which upon final acceptance becomes one term in the final agreement.

The Offer. An offer is a conditional promise or set of promises of reasonably certainty in the essential terms of the promised performance, manifested with contractual intent and communicated to the offeree by means chosen by the offeror.

An offer tendered can experience one of three outcomes; specifically, (1) it may be accepted as stated, (2) it may be rejected totally, or (3) it may be accepted in part and rejected in part. The outcomes of full acceptance or total rejection are simply understood. A partially accepted offer, however, is not an acceptance, but rather becomes a counteroffer. Under this circumstance, the original offeror then becomes the offeree, at least, with regards to the particular point under negotiation. This process continues until full acceptance or total rejection occurs.

Allied health education institutions should take special note of the words "...by a means chosen by the offeror", included in the above definition of an *offer*. As mentioned earlier, it is quite usual for allied health program personnel to arrange clinical details by such means as telephone communications or correspondence. Implied then, is the proposition that an offer need not be reduced to writing in to "manner of acceptance", there may even be the presumption that an offer tendered by telephone or letter is accepted if affirmatively responded to by the same means of communication. To illustrate, an allied health program person who wrote to a hospital's clinical service director seeking a student slot commitment receives a reply from a clinical service director stating that it will accommodate "X" number of students as requested. Presto! A legally binding contract may just have been executed. The same result could emerge from a telephone conversation or any other means of communication.

The Acceptance. An acceptance is the offeree's manifestation of assent to the terms of an offer, done so through communication to the offeror of his/her manifested contractual intent and unqualified willingness to be bound by the terms of the offer.

Allied health education institutions again must realize that these types of acceptances may occur routinely through telephone communications or correspondence between program personnel. Further, allied health education institutions should recognize that an offer may be accepted only by the person to whom it is made or his/her agent. Also, since an offeror may even prescribe the place, time and manner of acceptance, an acceptance may take effect upon dispatch if the prescribed method of communication is used. Conversely, under no circumstances can mere silence be construed as an effective acceptance of an offer. In other words, a program director cannot state something like, "if I do not hear from you by Tuesday we will send two students the following week."

3. Bargained-for Consideration

Consideration is defined as the exchange which the promisor requests in return for his/her promise. In general, an offer and an acceptance is not contractually enforceable unless supported by consideration. While consideration is oftentimes something of economic value, that is not always the case. The so-called bargained-for exchange must involve "legal benefit" to the promisor or some third person and/or "legal detriment" to the promisee

or some third person. Legal benefit may be defined as the gain of a legal right or the release from a legal obligation, while legal detriment may be defined as the loss of a legal right or the undertaking of a legal obligation. Consideration is oftentimes described as being "sufficient", "valuable" or "good". In most states, "good" consideration is similar to a moral obligation and therefore does not qualify as sufficient consideration to make a contract. Consideration is a concept somewhat more mystical than either an offer or an acceptance. The word consideration need not even appear in a contract. Rather, there is only the requirement that consideration itself be present; or in other words that a court can find the requisite "legal benefit" or "legal detriment" to support the offer and acceptance.

When two parties to a proposed contract are legally competent and when the terms and conditions of that contract have been agreed through genuine assent, an intended contract, written or oral, becomes an actual contract only when the three elements of *offer*, *acceptance* and *consideration* coalesce.

An allied health education institution, as the offer in contract negotiations, can gain a legal benefit sufficient to satisfy the requirement of bargained-for consideration from such things as: (1) a place to train its students, (2) increase in quality of its professional education programs, or (3) the possibility of increased tuition income by virtue of being able to assign additional students to clinical slots covered by the agreement. Similarly, an allied health education institution can gain benefits for its students in terms of the "third party" interest aspect of the legal definition of consideration. Similarly, an allied health education institution, as the promisee in contractual negotiations, can incur legal detriment by such things as: (1) having to supervise students in the off-campus clinical situation, (2) having to pay a clinical affiliate for teaching services, (3) having to grant adjunct clinical faculty appointments, or (4) providing services to clinical faculty such as tuition remission, use of campus facilities (library, tennis courts, pool) or parking privileges.

In short, legal consideration generally would not be difficult for a court to find with respect to the typical academic institution/clinical facility affiliation.

4. Purpose Not In Violation Of Public Policy

In general, parties can agree to do anything, whenever and under any circumstances they wish so long as the necessary requisite can be met for forming a legal contract. On the other hand, even though an agreement may satisfy all requisites for making a valid contract, the contract will be unenforceable if it violates public policy. Public policy, broadly defined, is anything injurious to the common welfare. Obviously, illegal acts are against public policy. Less obvious, are those acts which are legal but, nevertheless, are against public policy; e.g., agreements that tend to disrupt domestic relations or encourage divorce between adults, wagering agreements or lobbying agreements which contemplate the use of improper means to produce legislative action. There are many other examples.

Most likely, agreements between academic institutions and clinical facilities for the education of students in the allied health professions would not be construed as against public policy. There is, though, a trend to include so-called *hold harmless* clauses in such agreements.

Unfortunately, most clinical affiliation agreements are unclear as to just what acts these hold harmless clauses are intended to cover. While it is perfectly acceptable for one party to hold another harmless for such things as cost of litigation, accidental injury to the party himself and other similar type events, holding another harmless for certain other acts will make a contract unenforceable.

For example, the intent of most clinical institutions requiring hold harmless clauses seems to be to exempt them from liabilities caused by negligence. On this point, an agreement that attempts to relieve a person from liability resulting from his *willful* or *gross* negligence is illegal. On the other hand, an agreement relieving a party from *ordinary* negligence is legal so long as no duty is owed to the public. Still, even under this latter legal situation, courts are reluctant to enforce such provisions unless the contracting parties have equal bargaining power.

The potential illegality of hold harmless clauses should be a major concern for institutions entering into clinical affiliation agreements. An agreement which contains one promise to perform several acts in return for consideration is usually characterized as *indivisible*. Accordingly, if any one of the acts is illegal (e.g., an illegal hold harmless provision), the entire agreement is unenforceable. By contrast, an agreement containing several promises, each of which is supported by separate consideration is considered *divisible*. Thus, one or more illegal promises will not void the agreement. The probabilities are that affiliation agreements between academic institutions and clinical affiliates are of the indivisible type.

In summary, attempts by one party or the other to an affiliation agreement to require insertion of a hold harmless clause could have the inadvertent effect of making the entire agreement unenforceable. At best, the insertion of hold harmless clauses brings any agreement under a cloud of legal suspicion. It would seem far better to insert clauses affirming just what responsibilities both parties have for various types of liabilities rather than clauses holding one or the other parties harmless.

5. Form Required By Law

Contracts are valid no matter whether oral, written or, in some cases, implied by the acts of two parties. In other words, the law generally requires no specific form of contract so long as the parties are competent, they genuinely assent to the terms and the legal elements of an offer, acceptance and consideration can be found to exist. There certainly are advantages and disadvantages to both oral and written agreements, but as a general rule, there can be no real argument as to the superiority of written clinical affiliation agreements as compared to oral clinical affiliation agreements.

Written clinical affiliation agreements generally take the form of either letter agreements or formal instruments. A letter agreement emerges as a result of one party reducing the understanding of both parties into the form of a letter, signing and sending it to the second party. Legally, such a letter amounts to a valid offer. The receiving party who similarly signs the letter, returning it to the sender, has executed a legal acceptance. One advantage of letter agreements is that they generally contain less "legalese" than formal instruments and are

more easily understood by the lay person. The disadvantage is that in prosaic simplicity, it is probable that some important legal "buzz words" will be omitted inadvertently.

Formal agreements, on the other hand, are documents in which the intent and obligations of the parties are described in detail through a series of sections and clauses. Some obvious advantages of formal instruments are, that if properly drafted, the document describes the who, what, where, when and why of the relationship with sufficient specificity so that in the event that something goes wrong or a disagreement arises, reference to the document should indicate with whom the fault or responsibility lies. A major disadvantage of such instruments is that the documents may be so lengthy and so filled with legal jargon that only an attorney can fully understand them. Therefore, while oral agreements may be appropriate for short-term training experiences such as clinical observation, they usually are not appropriate for major clinical training. Letter agreements, like oral agreements, may be quite useful for short-term experiences and may possibly be appropriate for major clinical training experiences, if carefully drafted. Formal instruments should be used in any affiliate relationship where money or other compensatory benefits are given in return for training students. Without question, formal instruments are the recommended documents for major clinical training experiences.

There is one major exception to the earlier statement that contracts are valid, no matter in what form they are executed so long as the proper legal requisities are met. This exception is that the so-called *Statute of Frauds* requires that certain types of contracts, in order to be enforceable, must be in writing. The Statute of Frauds is a general term applied to legislation directed toward the purpose of preventing fraud. An obvious example of a contract covered by the Statute is an agreement for the sale of real estate. It is common knowledge that real estate contracts must be written and transfer of property made by written deed. The type of clinical affiliation agreement that typically falls within the provision of the Statute of Fraud is one, which by its terms, cannot be performed within a year from its making. In other words, any contract covering a time interval in excess of one year must be written.

6. Other Considerations

A. Assignment. As a general rule, only parties in privity have rights and obligations under a contract. Nevertheless, most contract rights can be assigned to others by either party to a contract unless the contract itself provides some limitation or prohibition against such assignment. Without such limitation or prohibition, any contract right can be assigned without permission of the other party so long as: (1) there is no material change in the duty of the other party, (2) there is no material increase in the burden of risk imposed on the other party, or (3) there is no material impairment on the other party's chances of return performance.

Where contract rights have been effectively assigned, the assignee acquires whatever rights the assignor had against the other party. That is, where it can make no difference to the other party whether performance is given to the assignee rather than the assignor, the mere fact that there is a different party does not prevent assignment.

The concept of legal assignment is important to allied health education institutions. An extreme scenario will serve to make this point. Suppose academic institution "A" contracts with clinical institution "X" to deliver clinical training services to "A's" students in medical technology. In the absence of an agreement against assignment, "X" could assign its rights and obligations under the agreement to clinical institution "Y", a hospital located in another state some several hundred miles distance. Obviously, the negative impact of such an assignment upon "A" and its students potentially could be severe. Other, less severe, variations of this risk of assignability easily could be conjectured. However, the conclusion that allied health education institutions should make from this extreme scenario, is that their typical affiliation agreement should include at least some limitation, if not a prohibition, against assignment.

B. Discharge. The legal term *discharge* refers to the termination of one or more legal obligations of a contractual relationship. The most straightforward method of discharging contractual obligations is through the exact and complete performance of those obligations. Anything less than complete performance does not have that effect, and a party who does not fully perform may be liable for *breach*. Still, there are several circumstances under which contractual obligations may be discharged even though nonperformance or incomplete performance has occurred. First, the parties may agree to a *mutual rescission* in which they simply execute what amounts to a second agreement to suspend the first agreement. Second, the parties may agree upon a *substituted contract* which is an entirely new agreement or introduction of new terms into the old contract. Third, the parties may agree through the legal doctrine of *novation* to substitute new parties for the original contracting parties. Finally, one party may give a *written release* which, in most states, must be supported by consideration. Anything else or failure to fulfill a major element of a contract amounts to breach.

C. Breach. A contract is breached when there occurs any unjustified failure to perform all or part of what has been agreed in a contract. As mentioned earlier, courts generally do not require specific performance of contractual obligations but rather seek to compensate the party against whom the breach has worked for "actual" or "compensatory" damages. Damages are awarded in the form of a money judgment that represents the value of the legal injury caused by the breach. In order to be so "compensated" for the legal damages incurred by having been the victim of a performance failure by another party, an injured party has the burden of proving the extent of these injuries in terms of monetary value with reasonable certainty. Speculative money damages are not awarded.

Under certain circumstances, even if a contract is legally breached, the breaching party may be excused for nonperformance. For example, if performance becomes impossible through a cause not due to the breaching party's own fault, the nonperformance may be excused. Second, accidental destruction of the specific subject matter or thing essential to the performance of contractual obligations may excuse nonperformance. For example, if a clinical facility in which allied health students were being trained was destroyed by fire, that clinical affiliate would not be held to their obligation to provide training services. Third, a supervening illegality or a frustration of purpose will similarly excuse contractual nonperformance. Although supervening illegalities likely will not impact educational programs, suppose an

academic institution lost its accreditation for a particular allied health program or lost its state funding. Clearly, the purpose of any contract based on the continuance of such things would have been frustrated. Under such circumstances, courts probably would excuse the academic institution for nonperformance of its duties under the contract. On the other hand, impracticability arising from unexpected difficulty or expense does *not* excuse contractual obligations. Lastly, either wrongful prevention by one party or a material breach by one party will usually excuse nonperformance by the other party.

D. Elements of a Clinical Affiliation Agreement (Formal Instrument)

What follows is an overview presentation of those elements considered essential to a clinical affiliation agreement executed by formal instrument. Care in addressing each of these elements in detail should not only eliminate disagreements between the parties, but also should make judicial interpretation of an agreement relatively easy should disputes arise.

Element No. 1, Identification of Parties. Parties should be identified with specificity. This identification should include not only the legal name of the parties but also their principal place of business. This latter item may become important for determining judicial jurisdiction in the event of dispute does arise.

Element No. 2, Purposes of the Contract. These clauses should describe the intent and motive of each of the parties entering into the agreement. There are basically two approaches to drafting such purpose clauses. Some writers use so-called "recital" clauses followed by a conclusion. These are the typical "whereas" clauses. Consider the following:

Whereas, "A" university has a college of allied health with students enrolled in the medical record administration program, and

Whereas, "B" hospital has the facilities for the clinical instruction of said students,

Therefore, it is agreed that, for the purpose of furthering the following objectives of the parties hereto, that "A" university will send to "B" hospital students enrolled in the baccalaureate program of medical record administration in the college of allied health who desire to receive instruction and clinical experience...

Other writers prefer to state the purpose of a contract in a paragraph that describes the background and motives for entering into the agreement. Consider the following:

The parties desire to engage the participation of the clinical center in the education of occupational therapy students from the "A" university's college of allied health, and thereby to promote excellence in patient care and education and contribute to the professional growth and competence of students in occupational therapy. By agreeing to co-

operate in accomplishing these common objectives, the two parties hope to further mutual understanding and programs of mutual interest.

Elements No. 3, Definitions. This element, while optional, may be desirable in lengthy documents or in contracts where money or compensation is involved. The following are some examples of the type of terms that might be defined in the definition section of an agreement:

Notice — signed writing by one party to the other that is effective when mailed (notice is relevant to provisions regarding termination or modification of the agreement, or to discharge of a student).

Clinical education — explains whether the agreement includes lecture, in-services, field trips in addition to "hands on" experience, etc.

Adequately prepared student — defined by such factors such the number of academic terms completed, grade point average.

Clinical supervisor — defined by such factors such as academic preparation, experience, description of type of degree of control over students.

Element No. 4, Term of the Agreement. This easily understood element should include such things as: When does the agreement start? When does it end? May it be terminated earlier? If so, for what reasons and by whom? May it be renewed? If so, how?

Element No. 5, Remuneration. This easily understood element should contain details about the amount and date of payments to be made under the agreement. For example:

"A" university shall pay "B" hospital \$500/student, payable not later than two weeks prior to the end of the students' clinical training.

This element should also contain other benefits such as faculty appointments for clinical instructors, tuition remission, parking privileges and the like.

Element No. 6, Joint Responsibilities. This element contains those things to which both parties agree. It would include such things as nondiscrimination clauses, a statement about the number of students to be placed and dates of assignments, statements about conferences regarding students' performance during clinical training, statements about cooperative efforts and curriculum development and evaluation and statements about procedures and reasons for discharge of a student. This last item should address: who has the ultimate power of discharge, reasons for discharge and the due process requirements.

Element No. 7, University Responsibilities. This element obviously lists those things for which the academic institution is responsible, such as:

1. The responsibility to assign only adequately prepared students.
2. The responsibility to identify and provide the services of a clinical coordinator.
3. Statements about making certain warranties about students prior to sending them to the clinical facility. For example, warrant that the student is covered by malpractice insurance, warrant that the student has been told the rules and regulations in the clinical facility and has agreed to obey those rules and regulations and warrant that the student shall submit to a physical examination, if required by the clinical facility.
4. Statements providing the clinical director with information on students at certain points in the students' training. For example, this provision may require the university to provide various information about students to the clinical director no less than "X" weeks prior to the commencement of the students' clinical training. Note, an academic institution should have students sign an information release waiver so that it can meet the provisions of such clauses as this and to comply the Privacy Act.
5. Statements about medical insurance.

Element No. 8, Clinical Facility Responsibilities. This element should contain various statements and clauses specifying those responsibilities resting with the clinical facility. For example:

1. Identification of the clinical supervisor and a statement agreeing to provide the services of that individual.
2. A statement that the clinical facility will provide supervision in proportion to the competency of the student's performance.
3. A statement that the clinical facility will make available to students opportunities to attend in-service, ward rounds and other agreed upon educational experiences.
4. A statement that the clinical facility will provide clinical experiences in various units of its facility.
5. A statement that the clinical facility will periodically provide to the university a list of all personnel at the clinical facility involved in supervising or evaluating students.

6. Assurance that the student's role in the clinical facility be that of a *learner*; that is, that students would not be expected to perform services in lieu of or as substitutes for staff members.

Element No. 9, Modifications and Amendments. There should be a statement specifying how modifications can be made and under what conditions. For example:

1. In writing.
2. Dated and signed by both parties.
3. Annexed to the original document.

Element No. 10, Indemnification. This element is where the academic institution or clinical facility can agree to be responsible under specific circumstances, and also where the controversial *hold harmless* clauses would be inserted if the institutions decide it appropriate. Better than hold harmless, though, would be an indemnification clause such as a clause stating that the academic institution will pay for litigation costs if any personal injury or property damage resulting from the students' practice.

The indemnification clause is usually the most controversial clause in any affiliation agreement because it tends to place a greater financial risk on one party or the other. Further, other intervening legalities may affect this clause no matter what the intent of the parties. Again, one example is the illegality of *hold harmless* clauses that are construed as contrary to public policy. Additionally, public institutions which have charitable immunity may be reluctant to volunteer to pay for something for which they could not be otherwise sued or held liable.

Element No. 11, Assignment. This is where the parties should limit, perhaps even prohibit, assignment of their duties and obligations within the agreement. These limitations or prohibitions may be as narrow or broad as the parties deem proper.

Element No. 12, Signatures. Written agreements must be signed by legally competent individuals. Academic institutions and clinical facilities, usually operating under corporate structures, "sign" by its officer who is *legally* authorized to bind the corporation.

SAMPLE AFFILIATION AGREEMENT

Example. What follows is an example of an affiliation agreement used by one major allied health education institution. This agreement is included only to exemplify a detailed formal instrument appropriate for major clinical affiliations. The actual terms and conditions of any other institution's agreements may of course vary significantly.

MEDICAL RECORD ADMINISTRATION PROGRAM

Affiliation Agreement

Between

_____ UNIVERSITY AND _____ HOSPITAL

AFFILIATION AGREEMENT between _____ University, address
_____ (hereinafter UNIVERSITY) and _____ Hospital,
address (hereinafter HOSPITAL).

The purpose of this AFFILIATION AGREEMENT is to establish the terms and conditions by which the HOSPITAL shall provide clinical education experiences in its Medical Record Department for the UNIVERSITY's Medical Record Administration students.

The parties recognize that both academic and clinical institutions have vested interests in providing structured clinical experiences and education activities for Medical Record Administration students. By agreeing to cooperate in accomplishing these common interests, the parties hope to further mutual understandings and programs of mutual interest, to further excellence in Medical Record Administration education, to further professional growth and competence of Medical Record Administration students and practitioners, to further the availability of much needed Medical Record Administration manpower and to further excellence and competence in patient care.

Therefore, the parties agree as follows:

A. The UNIVERSITY agrees to:

- (1) Admit only those students to its Medical Record Administration Program who have completed all programmatic prerequisite courses and who have competed successfully with other applicants for a position in each annual class. Admission is open to UNIVERSITY students as well as to students who may transfer to the UNIVERSITY from other education institutions. Both the admission process and the evaluation of clinical courses for transfer credit shall be directed by the Medical Record Administration Admission Committee described hereinafter at § D(2).
- (2) Provide the services of a Medical Record Administration Program Director as a liaison between the UNIVERSITY and HOSPITAL. The Program Director's duties to the HOSPITAL shall include but shall not be limited to the following:

- (a) Provide student data sheets on each UNIVERSITY student scheduled to be trained at the HOSPITAL not less than two weeks prior to said student's commencement of HOSPITAL training.
 - (b) Plan visits and consultants between the Program Director and the HOSPITAL as are necessary to promote exchange of information relevant to a student's clinical education experience at the HOSPITAL.
 - (c) Provide evidence satisfactory to the HOSPITAL that all matriculating students carry student professional liability insurance.
 - (d) Advise students of their responsibilities during the clinical education at the HOSPITAL.
- (3) Grant the HOSPITAL's Medical Record Department's Clinical Education Supervisor, described hereinafter at § B(1), a courtesy adjunct appointment to the UNIVERSITY faculty.
 - (4) Assure the HOSPITAL that students assigned to the HOSPITAL meet both UNIVERSITY and HOSPITAL standards of health.

B. The HOSPITAL agrees to:

- (1) Designate a Medical Record Administration staff member acceptable to the UNIVERSITY as Clinical Education Supervisor. The Clinical Education Supervisor's duties shall include but shall not be limited to the following:
 - (a) Coordinate and direct each UNIVERSITY student's clinical education.
 - (b) Provide a planned clinical experience that meets the requirements set forth hereinafter in § C(10).
 - (c) Provide orientation for UNIVERSITY personnel and Medical Record Administration students to the HOSPITAL's clinical facilities.
 - (d) Provide reasonable notice to the UNIVERSITY's Program Director of any situation or problem which may threaten a student's successful completion of his/her clinical education.
 - (e) Provide grades for UNIVERSITY students engaged in clinical education at the HOSPITAL in the manner prescribed by the UNIVERSITY's Program Director.

- (2) Provide reasonable student facilities such as classrooms or conference rooms.
- (3) Make available to the students the HOSPITAL's library facilities.
- (4) Provide clinical educational experiences in selected services and units of the HOSPITAL, allowing the student participate as determined by applicable policies of the HOSPITAL.
- (5) Make available to students other HOSPITAL learning experiences such as ward rounds, staff conferences, in-service education, and similar activities at the discretion of the Clinical Education Supervisor.
- (6) Provide adequate student supervision by registered medical record administrators or accredited record technicians and maintain an adequate level of staff support to carry out normal patient service functions so that students will not be expected to perform patient services in lieu of staff.
- (7) Provide the UNIVERSITY with a list of all HOSPITAL personnel, together with said personnel's professional and academic qualifications, supervising UNIVERSITY students or otherwise participating in the student's clinical educational experience.
- (8) Grant the UNIVERSITY's Medical Record Administration Program Director a courtesy consultant appointment in Medical Record Administration Education or other courtesy appointment in the Medical Record Department.

C. Both parties agree that:

- (1) There shall be no discrimination against students on the basis of race, religion, sex, national origin or handicap.
- (2) The number of students, dates of assignments and availability of the HOSPITAL clinical education opportunities shall be determined by the HOSPITAL's Clinical Education Supervisor and UNIVERSITY's Program Director.
- (3) The students shall be advised and required to adhere to the rules and regulations of the HOSPITAL, including observation of the HOSPITAL's hours of work and dress standards, and participation in Medical Record Department activities, including after-hours and in-service education programs and continuing education opportunities.
- (4) Each party shall inform the other in a reasonable time of the following:
 - (a) Changes in academic curricula.
 - (b) Changes in the availability of learning opportunities.
 - (c) Staff changes affecting either academic preparation or clinical teaching of students.

- (5) Withdrawal of a student from clinical assignment may be requested by either the HOSPITAL or UNIVERSITY. The party requesting such withdrawal shall notify the other party and the student in writing. Such withdrawal shall occur only upon the following terms and conditions:
- (a) The Medical Record Administration Admission Committee shall review the student's record and other appropriate items and shall afford the student an opportunity to respond to allegations against him/her before any disciplinary action is taken.
 - (b) Academic suspension of students shall be based on UNIVERSITY policy.
 - (c) A student who withdraws from a course for academic reasons is not prohibited from repeating that course.
- (6) Reports, data, self-studies and other reasonable information that may be requested by either party or reasonable information that may be required by the Education and Registration Committee of the American Medical Record Association, the Committee on Allied Health Education and Accreditation, the North Central Association of Colleges and Secondary Schools or other relevant professional accrediting agencies or governmental bodies shall be completed and exchanged between the parties as necessary.
- (7) Students must enroll in clinical courses at the UNIVERSITY. Close communication between the parties regarding the number of students being counseled and programmed into the clinical courses provides advance knowledge as to the space needed. A student may enroll in clinical courses only after his/her credentials have been evaluated by the Medical Record Administration Admission Committee and he/she has been accepted into the UNIVERSITY's Medical Record Administration Program.
- (8) Cooperative effort is required between the HOSPITAL's Clinical Education Supervisor and the UNIVERSITY's Program Director regarding the following:
- (a) Scheduling of clinical courses.
 - (b) Assignments of students in the clinical program.
 - (c) Providing pertinent schedules, dress and/or uniform regulations and establishing the level of professional standards for students.
 - (d) Implementing standardized clinical evaluation and grading policies for students.
 - (e) Development of the professional curriculum.

- (f) Development of professional course objectives.
- (g) Periodic evaluation and revision of both the professional curriculum and professional course objectives.
- (9) Any modification or recommended change in the Medical Record Administration curriculum must be approved by the appropriate faculty and administrative authorities of the UNIVERSITY as follows:
 - (a) Changes of course content, instructors or scheduling shall be decided at the departmental level through usual UNIVERSITY channels.
 - (b) Major modifications of curriculum require approval of the College Curriculum Committee, the Dean of the College of Allied Health and, where applicable, the Graduate Council.
 - (c) Any changes or modifications in the curriculum which shall affect the rights or duties of either party to this AFFILIATION AGREEMENT must be agreed mutually.
- (10) The Medical Record Administration Program, both the academic phase and the professional phase, shall conform to the *Essentials of an Accredited Education Program for the Medical Record Administrator* as adopted by the American Medical Association and the American Medical Record Association.

D. COMMITTEES

The functioning of the Medical Record Administration Program at the UNIVERSITY is coordinated by the following two bodies:

- (1) **MEDICAL RECORD ADMINISTRATION ADVISORY COMMITTEE:**
The Advisory Committee is composed of the UNIVERSITY's Program Director, described *supra* at § A(2), who shall act as chairperson, medical record educators, affiliation site supervisors, one (1) senior Medical Record Administration student from the UNIVERSITY and other health-related personnel.

FUNCTION:

- (a) Advise the UNIVERSITY on the need for the Program in the state or region and the opportunities for employment of graduates.
- (b) Assure that the Program conforms with the *Essentials for Accredited Educational Programs for the Medical Record Administrator*.

- (c) Provide information on the availability of a sufficient number of appropriate clinical practice sites in the area suitable for the Medical Record Administration Program.
- (d) Provide the mechanism for professional contributions of the content of courses and the design of a curriculum for specific knowledge and skills required by Medical Record Administrators.
- (e) Serve as communication linkages between interested occupational and professional groups in the community and the UNIVERSITY.
- (f) Keep the UNIVERSITY and Program Director informed of changes in health care and in Medical Record Administration practice which should be reflected in the University's Program.
- (g) Assist in the formulation of standards for admission to the Program.
- (h) Assist in recruitment of qualified faculty members.
- (i) Assist UNIVERSITY in obtaining suitable agreements with medical care institutions to provide clinical practice for students.
- (j) Help to assure the UNIVERSITY administration that the program has the understanding and support of the HOSPITAL community.

(2) **MEDICAL RECORD ADMINISTRATION ADMISSION COMMITTEE:**

The Admission Committee is composed of the UNIVERSITY's Program Director, described *supra* at § A(2), who shall act as chairperson, the faculty of the Medical Record Administration Program, and one (1) representative from the Advisory Committee.

FUNCTION:

- (a) Review applications of prospective candidates for admission into the Medical Record Administration Program.
- (b) Interview prospective candidates for the Medical Record Program.
- (c) Evaluate professional clinical courses of transfer students.
- (d) Review petitions for readmission from Medical Record Administration students who have withdrawn voluntarily from the Medical Record Administration Program.

- (e) Review recommendations for involuntary dismissal of a student from the Medical Record Administration Program.

E. RENEWAL OF AFFILIATION AGREEMENT

- (1) This AFFILIATION AGREEMENT shall be effective as of the date on which it is signed by the parties.
- (2) This AFFILIATION AGREEMENT shall be renewed in January of each academic year. Should either party desire to terminate this AFFILIATION AGREEMENT, notification shall be given to the other party in writing not less than six (6) months prior to the proposed date of termination. The term academic year for the purpose of this AFFILIATION AGREEMENT shall mean a period of time which begins on May 1st and ends August 20th. By agreeing to a six (6) month notice of termination, the parties express their mutual belief that their respective vested interests in this AFFILIATION AGREEMENT will be served best by allowing currently matriculated students reasonable time to complete their programs of study.
- (3) Should the Committee on Allied Health Education and Accreditation revoke its Accreditation of the UNIVERSITY's Medical Record Administration Program, this AFFILIATION AGREEMENT shall remain in effect only until the conclusion of the then existing academic year.
- (4) Inasmuch as it is anticipated that future courses will be developed to supercede and/or complement courses presently constituting the UNIVERSITY's Medical Record Administration Program, and inasmuch as it is further anticipated that other unexpected factors may impact this Program, it is agreed that the parties may modify or amend this AFFILIATION AGREEMENT without altering the basic AFFILIATION AGREEMENT provided that such modifications or amendments shall be in writing and signed by both parties.

F. ASSIGNMENT

The terms of this AFFILIATION AGREEMENT may not be assigned unless agreed in writing by the parties and affixed hereto as amendment.

G. STATEMENT OF AGREEMENT

In testimony whereof this AFFILIATION AGREEMENT between _____
_____ UNIVERSITY and _____ HOSPITAL is
effective as of this ____ day of ____, 1982 by their authorized representatives signed
below.

_____ UNIVERSITY _____ HOSPITAL

BY: _____
PRESIDENT

BY: _____
PRESIDENT

SUMMARY

It behooves academic institutions, either developing or operating allied health education programs to give appropriate attention to the matter of clinical affiliation agreements. Their very activities require that they interact with health care facilities to some extent. These institutions must determine how much or how little control that they desire to exert upon their student's education in these off-campus environments. The trend clearly is toward academic institutional control of students while they are in clinical facilities. This trend implies the need for detailed affiliation agreements spelling out the rights and obligations of the parties. Parallel with this situation is the reality that allied health programming is generally negotiated at the program director level, both on the college campus and in the clinical institution. Therefore, it is incumbent upon academic institutions to recognize the contractual roles that their program personnel play and provide the appropriate support mechanisms for assuring contractual effectiveness.

Education institutions involved in even a few allied health programs may operate under numerous clinical affiliation agreements, each separately negotiated and containing varying terms, conditions and dates. It is practically impossible to bring uniformity to these agreements unless the institution provides appropriate support services to manage the numerous agreements. Utilization of the services of personnel trained in contractual development can lead to such desirable outcomes as avoiding misunderstandings and determining the consequences under a variety of occurrences and circumstances. Properly managed, errors should be kept to a minimum thereby avoiding unintended breach. The main victims of a breach, no matter what the reason, are the students.